Resident Physician

JUNE
1961

BUY A PRACTICE ?

7 Ways to Read 5,000 Medical Journals

• Ohio Conference on Internship

In a series of 24 handicapped arthritics treated with dexamethasone for 8 to 16 months, ring size decreased consistently — objective evidence of antirheumatic effects which were maintained throughout the entire period of observation. Improvement was also noted in other antirheumatic indices, i. e., pain on motion, tenderness, swelling and morning stiffness.[1]

Supplied: as 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate and new Elixir DECADRON. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

Reference: 1. Bunim, J. J., in Hollander, J. L.: Arthritis and Allied Conditions, ed. 6, Philadelphia, Lea & Febiger, 1960, p. 364.

MERCK SHARP & DOHME
Division of Merck & Co., INC., West Point, Pa.

Decadron®

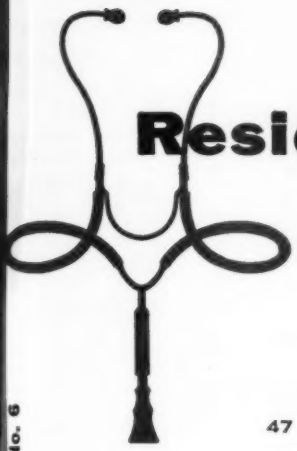
Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

See "Dr. B" on NBC-TV TUESDAY NIGHT, JUNE 27, 10P

June 1961, Vol. 7, No. 6

CONTENTS



Resident Physician

June 1961, Vol. 7, No. 6

Articles

The Resident Physician is published monthly on the fifteenth by The Resident, Inc., with publication offices at 34 North Crystal Street, East Stroudsburg, Pennsylvania. Executive, advertising and editorial offices at 1447 Northern Boulevard, Manhasset, New York. If undelivered, please send form 3547 to Resident Physician, 1447 Northern Boulevard, Manhasset, New York.

in G.I., G.U. and Biliary SPASM

"Murel"-S.A.

Sustained Action Tablets

prompt, continuous and prolonged antispasmodic action for 6 to 9 hours with a single tablet

"MUREL" Advantages[1-4]

- Exceptionally effective clinically because three-way mechanism of action in one molecule (anticholinergic, musculotropic, ganglion-blocking) exerts synergistic spasmolytic effect
- Complementary action permits significantly low dosage and reduces reaction potential of any one mechanism
- Remarkably free from drug-induced complications such as mouth dryness, visual disturbances, urinary retention

Suggested Average Dosage: 40 to 80 mg. daily, depending on condition and severity. The higher range of dosage is usually required in spasm of the genitourinary and biliary tracts. One "Murel"-S.A. Sustained Action Tablet morning and evening. *When anxiety and tension are present,* "Murel" with Phenobarb-S.A. is suggested.

Available as: No. 315—"Murel"-S.A., 40 mg. Valethamate bromide; and No. 319—"Murel" with Phenobarb-S.A., with ½ gr. phenobarbital, present as the sodium salt. Both in bottles of 100 and 1,000.

Also available: "Murel" Tablets No. 314—10 mg. Valethamate bromide; "Murel" with Phenobarbital Tablets No. 318—10 mg. Valethamate bromide and ¼ gr. phenobarbital.

"Murel" Injectable No. 405—10 mg. Valethamate bromide per cc.

Precautions: As with other antispasmodic agents, caution should be exercised in patients with prostatic hypertrophy, glaucoma, and in the presence of cardiac arrhythmias.

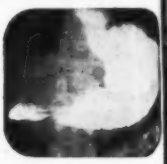
References available on request.

AYERST LABORATORIES
New York 16, N. Y. • Montreal, Canada

for acute, severe episodes
"MUREL" Injectable

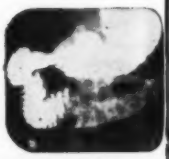
Female patient, age 55, complaining of nausea and epigastric discomfort after meals.

Diagnosis: Hiatus hernia and gastric ulcer.

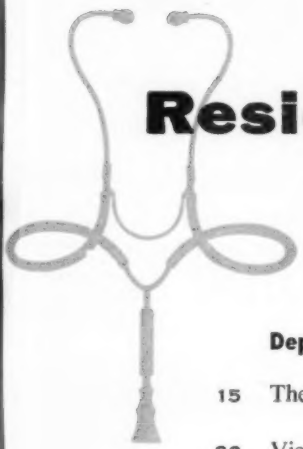


1 hour after barium administration: Retention of barium due to spasticity of the gastric outlet, and incomplete visualization of the pylorus, duodenum and duodenal sweep. (Some barium has entered the small bowel.)

20 minutes after administration of "Murel" 2 cc. I.V.: Barium entering duodenum and duodenal sweep as spasticity is relieved.



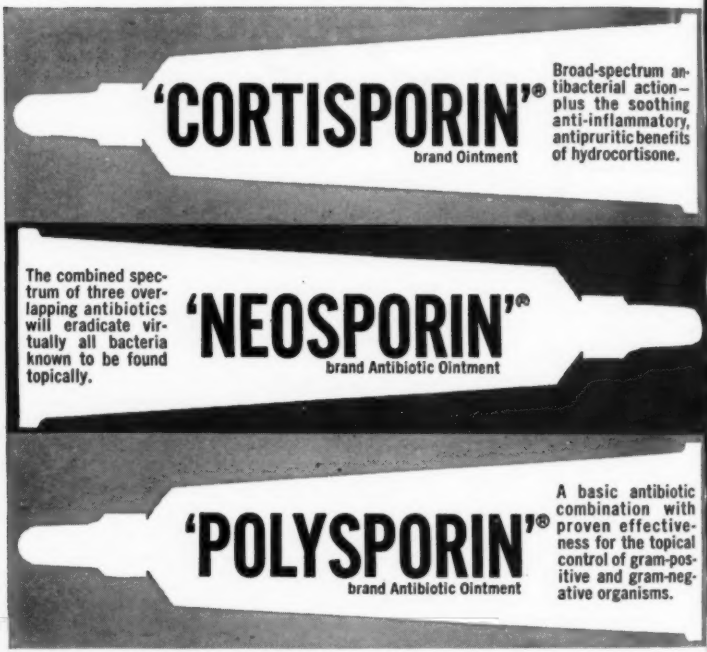
10 minutes later: Good filling of the gastric outlet as well as of the duodenal sweep.



Resident Physician

Departments

'B. W. & CO.' 'Sporin' Ointments rarely sensitize... give decisive bactericidal action for most every topical indication

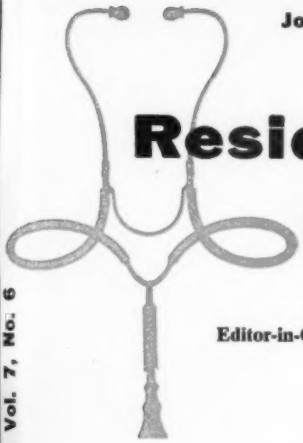


Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

June 1961, Vol. 7, No. 6

Journal for the Hospital Staff Officer

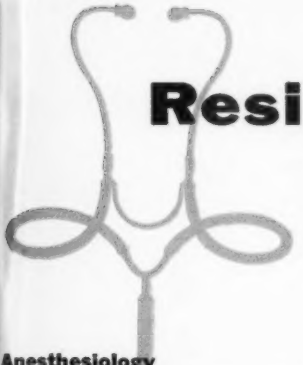


Resident Physician

June 1961, Vol. 7, No. 6

Articles are accepted for publication with the understanding that they are contributed solely to this publication, and will directly interest or be of practical value to resident physicians and interns. When possible, two copies of the manuscript should be submitted.

Subscription rate $10 per year. Single copies $1. Notify publisher promptly of change of address.



Resident Physician

Advisory Board

Anesthesiology

J. ADRIANI, M.D., Director, Department of Anesthesiology, Charity Hospital of New Orleans.

MAX S. SADOVE, M.D., Director, Department of Anesthesiology, University of Illinois.

Dermatology

MARION B. SULZBERGER, M.D., Professor and Chairman, Department of Dermatology and Syphilology, New York University Postgraduate Medical School.

General Practice

C. WESLEY EISELE, M.D., Chief, General Practice Residency Program, University of Colorado.

GEORGE ENTWISLE, M.D., General Practice Program, University Hospital, Baltimore.

Medicine

WILLIAM B. BEAN, M.D., Professor of Medicine, University of Iowa Medical School.

CHARLES DAVIDSON, M.D., Associate Professor of Medicine, Harvard Medical School.

C. WESLEY EISELE, M.D., Associate Professor of Medicine; Associate Dean in Charge of Post Graduate Medical Education, University of Colorado.

CHARLES L. LEEDHAM, M.D., Director of Education, Cleveland Clinic, Frank E. Bunts Educational Institute.

JOHN C. LEONARD, M.D., Director, House Staff Education, Hartford Hospital.

Obstetrics-Gynecology

ALAN F. GUTTMACHER, M.D., Director, Department of Obstetrics and Gynecology, Mt. Sinai Hospital, New York City.

Ophthalmology

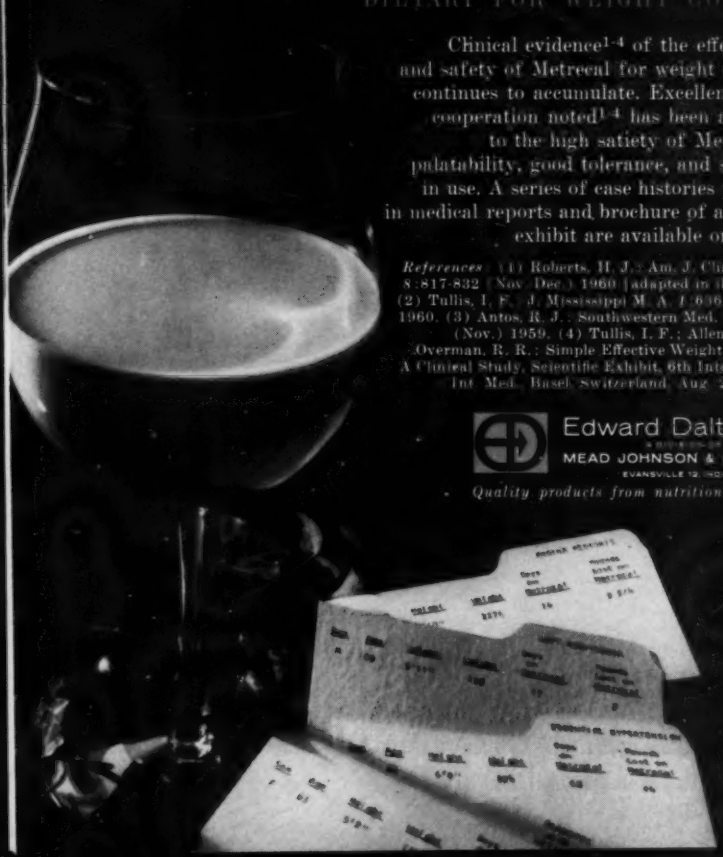
DERRICK T. VAIL, M.D., Chairman, Department of Ophthalmology, Northwestern University Medical School.

Orthopedics

HAROLD A. SOFIELD, M.D., Professor of Orthopedic Surgery, Northwestern University Medical School.

Otolaryngology

DEAN M. LIERLE, M.D., Chief, Department of Otolaryngology and Maxillofacial Surgery, State University of Iowa.



Pathol

JOHN R
of Path
Lincoln

Pediat

JAMES
cian-in-
pital.

Plastic

NEAL C
ic, Ne
of Surg
of Me

Psych

WILLIA
fessor
retary,
of Psyc

Public
Preve

HERMA
mission
York.

Radio

MAXW
ter of
Center

June 1

Resident Physician

Advisory Board

Pathology

JOHN R. SCHENKEN, M.D., Professor of Pathology, University of Nebraska, Lincoln.

Pediatrics

JAMES MARVIN BATY, M.D., Physician-in-Chief, Boston Floating Hospital.

Plastic Surgery

NEAL OWENS, M.D., The Owens Clinic, New Orleans; Clinical Professor of Surgery, Tulane University School of Medicine.

Psychiatry

WILLIAM C. MENNINGER, M.D., Professor of Psychiatry and General Secretary, Menninger Foundation School of Psychiatry.

Public Health and Preventive Medicine

HERMAN E. HILLEBOE, M.D., Commissioner of Health, State of New York.

Radiology

MAXWELL H. POPPEL, M.D., Director of Radiology, Bellevue Hospital Center.

Rehabilitation and Physical Medicine

SEDGWICK MEAD, M.D., California Rehabilitation Center, Vallejo.

Resident Staff Director

SALVATORE R. CUTOLO, M.D., Deputy Medical Superintendent, Bellevue Hospital Center.

Surgery

DONALD C. COLLINS, M.D., Assistant Professor of Surgery, College of Medical Evangelists.

EARL J. HALLIGAN, M.D., Director of Surgery, Jersey City Medical Center.

KARL A. MEYER, M.D., Chairman, Department of Surgery, Cook County Hospital.

HOWARD E. SNYDER, M.D., The Snyder Clinic, Winfield, Kansas.

Thoracic Surgery

PAUL C. SAMSON, M.D., Associate Clinical Professor, Stanford University School of Medicine.

Urology

HERBERT B. WRIGHT, M.D., Chief of Urology, Evangelical Deaconess Hospital, Cleveland.

Allergi
Tedral S
Twiston

Analge
Sedati
Alvodine
Butisol S
Cafergot
Dilaudid

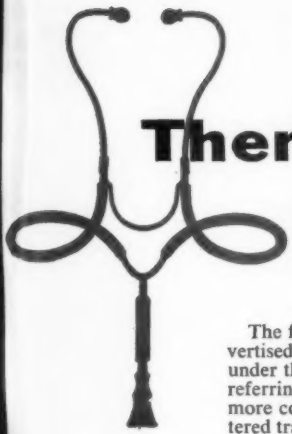
Antibio
therap
Albamyc
Declomy

Antico
Coumad

Antiem
Tigan

Antiinf
Varidase

June 19



Therapeutic Reference

The following index contains all the products advertised in this issue. Each product has been listed under the heading describing its major function. By referring to the pages listed, the reader can obtain more complete information. All products are registered trademarks, except those with an asterisk (*).

Diureti
Diuril

Equipn
Aloe Fu
Amsco
B-D Hy
Birtcher
Daily L
G-E Pa
Histaco
Rudich
Spray

Eye, E
Throat
Neo-Po

Femin
Tampax

Foods
Sustage

G.U. F
Antise
Furada
Gantris

Infant
Carnala
Sobee

Invest
Accide
Insur
Blue S

Laxat
consti
Dulcol
Phosph

Mens
Meno
Prema

June 1

not a general-purpose antibiotic

Albamycin is not a broad-spectrum antibiotic, recommended for routine infections. It is specific for staphylococci (including resistant strains), and its use alone should (with the exceptions listed below) be limited to those cases in which staph is known or strongly suspected to be the causative organism.

Albamycin*

Indications — Albamycin is indicated in the treatment of staphylococcic infections, particularly in patients sensitive to other antibiotics or in the infections in which the organism is resistant to other antibiotics and sensitive to Albamycin, and in urinary tract infections due to microorganisms resistant to other commonly employed antibacterial agents but sensitive to Albamycin — notably certain strains of Proteus.

Administration and Dosage — Capsules and Syrup: The recommended dosage in adults is 500 mg. every twelve hours or 250 mg. every six hours, continued for at least forty-eight hours after the temperature has returned to normal and all evidence of infection has disappeared. In severe or unusually resistant infections, 0.5 Gm. every six hours or 1 Gm. every twelve hours may be employed. The dose for children is 15 mg. per kilogram of body weight per day for moderately acute infections; this may be increased to 30 to 45 mg. per kilogram of body weight per day for severe infections. These doses may be administered on schedules similar to those for adults.

Parenteral: Intramuscularly — 5 cc. of Albamycin solution may be used directly by slow injection deep into the gluteal muscle.

Intravenously — it is recommended that 5 cc. of Albamycin solution be diluted further with 250 to 1000 cc. of sterile injection solution of sodium chloride, Darrow's solution, or Ringer's solution and administered by intravenous infusion, or by diluting to a suitable quantity and administered by continuous drip infusion. **Do not use with dextrose solution.** When it is necessary to use a smaller volume intravenously, 5 cc. of Albamycin solution may be diluted to a minimum of 30 cc. with one of the above diluents and administered slowly over a period of five to ten minutes to avoid irritation of the vascular endothelium. The dosage for adults is 500 mg. Albamycin administered either intramuscularly or intravenously every twelve hours. For children with moderately acute infections, the dosage is 15 mg. per kilogram of body weight per day. The daily dosage should be administered in two divided doses at intervals of twelve hours. As soon as the patient's condition permits, parenteral Albamycin should be replaced with oral Albamycin therapy.

Side Effects — Albamycin is a substance of low toxicity but is capable of inducing urticaria and maculopapular dermatitis. Leukopenia, which was rapidly reversible, has been reported in approximately 1% of cases. All of these side effects disappear rapidly upon discontinuance of the drug. In a certain few patients, a yellow pigment has been found in the plasma. This pigment is a metabolic by-product of the drug which, however, may interfere with determination of bilirubin and icteric index. Its presence is not associated with abnormal liver function tests or liver enlargement.

Available — Albamycin, 500 mg., sterile, Mix-O-Vial.† Each Mix-O-Vial contains: 500 mg. Novobiocin (as novobiocin sodium), also 175 mg. Nicotinamide; 0.47 cc. N,N-Dimethylacetamide; 42.3 mg. Benzyl alcohol; 4.23 cc. water for injection. Albamycin Capsules. Each capsule contains: 250 mg. Novobiocin (as novobiocin sodium). Albamycin Syrup. 125 mg. per 5 cc. Each 5 cc. (one teaspoonful) contains: 125 mg. Novobiocin (as novobiocin calcium). Preserved with methylparaben, 0.075%, and propylparaben, 0.025%.

*Trademark, Reg. U. S. Pat. Off. — The Upjohn brand of crystalline novobiocin sodium. †Trademark, Reg. U. S. Pat. Off.

The Upjohn Company
Kalamazoo, Michigan

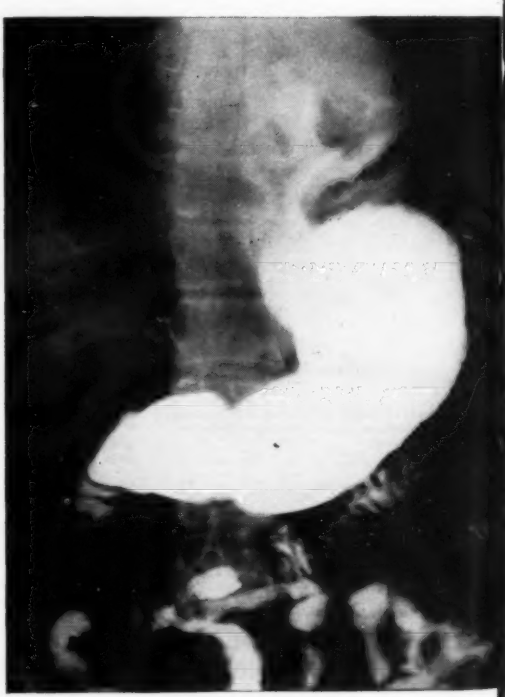
Upjohn

Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

What is your diagnosis?

Sixty-eight-year-old individual with marked dysphagia, loss of weight, weakness for the past seven months. This acute phase was superimposed on a chronic phase which consisted of epigastric discomfort and mild dysphagia for over twenty years.

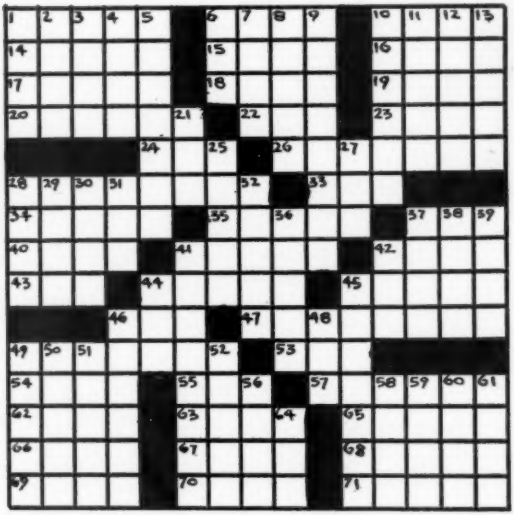


1. Diaphragmatic hernia
2. Gastric malignancy
3. Esophageal diverticulum
4. Perforation of the esophagus
5. Malignancy in paraesophageal hernia

(Answer on page 171)

Resident Relaxer

(Solution on page 171)



ACROSS

1. A depression, usually longitudinal
6. Tympanum of the ear
10. Ill-tempered person
14. Angry
15. Anterior portion of the third cerebral ventricle
16. To delineate
17. To diminish
18. Insinuate
19. Love (Lat.)
20. Slants
22. Sodium, einsteinium (symbols)
23. Produced
24. Gram-molecule (abbr.)
26. A minute drop
28. Inflammation of a nerve
33. Nickel, sulfur (symbols)
34. Auricles
35. Pertaining to a blood vessel
37. Cerebrospinal meningitis (abbr.)
40. Treat with contempt
41. Pertaining to the kidney
42. Genuine
43. Oxygen, arsenic (symbols)
44. Doctrine
45. Becomes bitter
46. Upper extremity
47. Become ill again after apparent cessation of disease
49. The itch
53. Reaction of degeneration (abbr.)
54. Vitiated, diseased (comb. form)
55. Small spot
57. Eye-piece of a microscope
62. Declare
63. Membrane behind the cornea
65. Deficiency (comb. form)
66. Indian title
67. In anatomy, any vaulted structure
68. Unbecoming
69. Snow vehicle
70. To distintegrate, as of cells
71. Sharp-pointed missiles

DOWN

1. Convulsions
2. Relating to the mouth
3. Soap
4. A pace
5. Presence of air in the blood vessels
6. Disordered action of the heart (abbr.)
7. Wreck
8. Toward the ulna
9. Pertaining to the mother
10. Surgical device for effecting compression (pl.)
11. Pertaining to a fissure
12. Positive electrode
13. Kind of hat
21. Drunkard
25. Animate
27. Liquid fat
28. Nose (comb. form)
29. Vessel for heating liquids
30. Extinct wild ox
31. Costa
32. Of sounder mind
36. Surfeited
37. Any anatomical structure resembling a leg
38. Certain
39. Hodgepodge
41. Curative
42. Summit
44. Three (prefix)
45. Resembling flesh
46. Away from the mouth
48. Man's name
49. Cicatrices
50. Relating to a vena cava
51. Suffix denoting relation to anthracene
52. Penitent
56. Habitual spasmodic movements
58. Bone of the forearm
59. One who lies down
60. Silver, platinum (symbols)
61. Decays
64. That woman

The Newest Most Brilliant Departure From The "Ordinary" in Professional Furniture

2nd Century ... by Aloe

Strikingly beautiful Vinyl permanently laminated to indestructible steel . . . functioning with an efficiency unknown in professional furniture until now... wider, more spaciously body-contoured treatment tables uniquely mechanized to raise or lower with "self-assisting" ease . . . vise-grip stirrup positioning locking at any height, length and spread . . . high impact, sound deadening Polystyrene drawers responding to a finger touch with full-width pulls, open quietly, smoothly . . . revealing coved bottoms to inhibit dust . . . are but a few of many features designed to lessen the fatigue of a modern practice . . . reflect the discriminating standards of today's physician.

Auxiliary pieces, cabinets and tables now on order in eight striking combinations of color and finish.

A. S. Aloe Company—A BRUNSWICK DIVISION
1831 Olive St., St. Louis 3, Mo.

Send your new 2nd Century Brochure illustrated in full color.

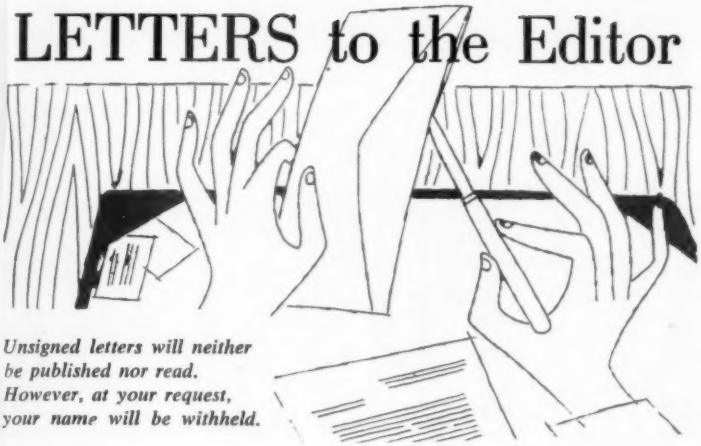
Name.....

Street.....

City.....State.....

11

LETTERS to the Editor



Unsigned letters will neither be published nor read. However, at your request, your name will be withheld.

Foreign MD's Social Security

I am a chief resident of medicine . . . I am in this country from Turkey on a student visa.

My question is: Is it a lawful procedure to be taking social security from my salary? Inquiries to other hospitals have resulted in a questionable issue. The tax department states that we are looked upon as employees of the hospital and not students and therefore taking social security from us is right and lawful. If this is the case, is there such a thing as filing an amended return before going back to our country, to get this money back? Otherwise, in order to ever get the use of the money we would have to come back to the U.S. at age 65 and file citizenship and old age.

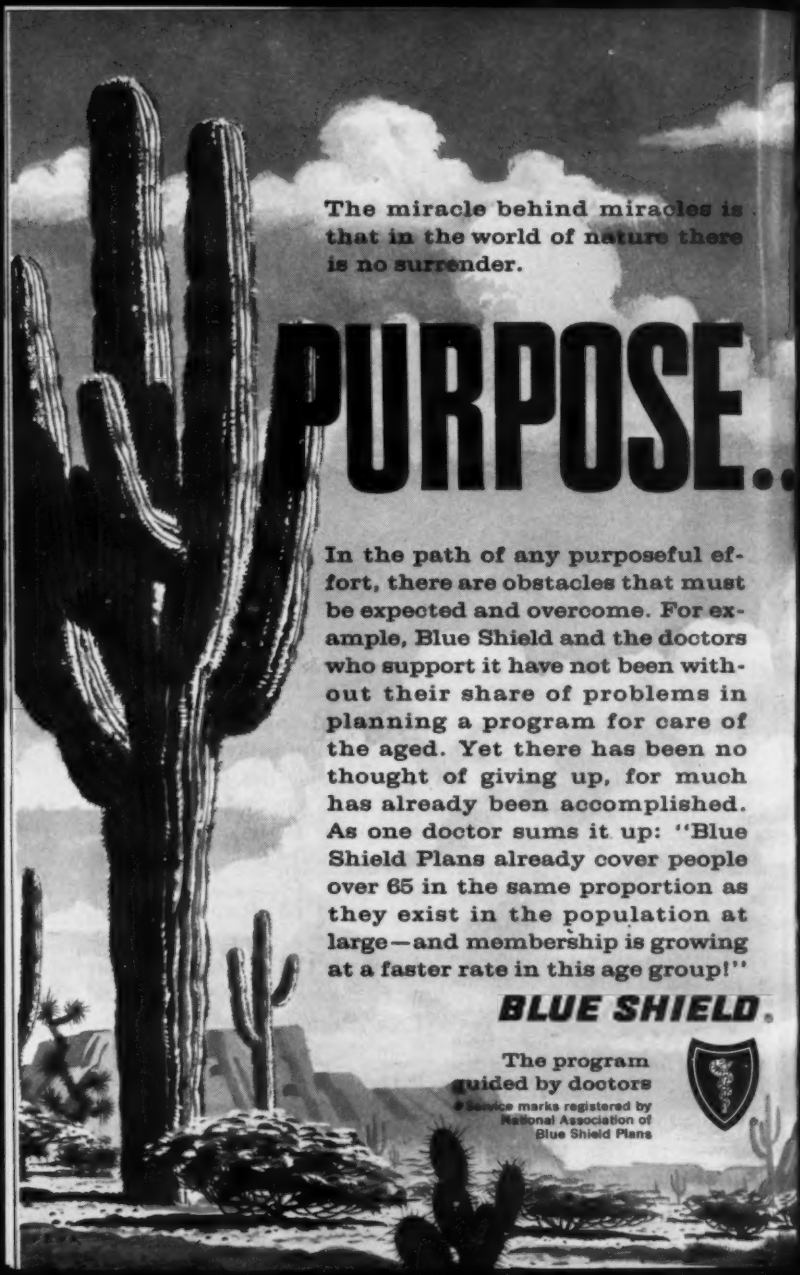
I would appreciate any comment or information you can give me regarding this matter.

NIHAT AKTURE, M.D.
ST. MARY'S HOSPITAL
CINCINNATI, OHIO

I am a physician from Iran, working as a resident in Radiology in the U.S.A. I came here as an Exchange Visitor in 1956 and I am returning home this July.

In the past five years, I have been paying from my meager stipend for Social Security as provided by law in this country. It

—Continued on page 36


The miracle behind miracles is that in the world of nature there is no surrender.
PURPOSE..
In the path of any purposeful effort, there are obstacles that must be expected and overcome. For example, Blue Shield and the doctors who support it have not been without their share of problems in planning a program for care of the aged. Yet there has been no thought of giving up, for much has already been accomplished. As one doctor sums it up: "Blue Shield Plans already cover people over 65 in the same proportion as they exist in the population at large—and membership is growing at a faster rate in this age group!"
BLUE SHIELD
The program guided by doctors
Service marks registered by National Association of Blue Shield Plans

n edema or hypertension

ore doctors are prescribing—

more patients are receiving the benefits of—

more clinical evidence exists for—

DIURIL®

CHLOROTHIAZIDE

han for any other diuretic-antihypertensive

URIL is unique. There is no other brand chlorothiazide.

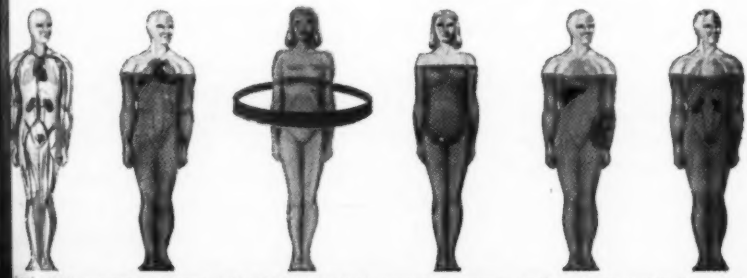
osage: Edema—One or two 500-mg. tablets URIL once or twice a day. Hypertension—e 250-mg. tablet DIURIL or one 500-mg. blet DIURIL two to three times a day.

Supplied: 250-mg. and 500-mg. scored tablets DIURIL chlorothiazide in bottles of 100 and 1000.

DIURIL is a trademark of Merck & Co., INC.

Additional information is available to the physician on request.

MERCK SHARP & DOHME
Division of Merck & Co., INC., West Point, Pa.



ERTENSION CONGESTIVE FAILURE PREMENSTRUAL TENSION EDEMA OF PREGNANCY CIRRHOSIS WITH ASCITES RENAL EDEMA

—*Continued from page 33*

is my belief that the requirement of "Social Security" payments from citizens of foreign countries temporarily residing in the United States, is totally unreasonable. It is very unlikely that this practice has any legal basis.

Since, as usual, I can find no responsible authority to refer to in matters concerning the foreign house staff, I am writing to you for information and guidance.

ABOL KHAJAVI, M.D.
JEFFERSON MEDICAL COLLEGE HOSPITAL, PHILADELPHIA, PA.

I am an Exchange Visitor . . . could you please give me an explanation as to why I am paying a Social Security tax?

I asked the Social Security Administrator for return of my Social Security tax when I leave this country, because I would not be in this country at 65 years of age. The answer was they would not return Social Security tax because the law said every resident employee has to pay this tax because he might stay in this country after 10 years.

Upon my question to the State Department, "Could I apply for citizenship (because I am paying for my retirement)?" I was answered that I cannot apply for citizenship because my status is under the law which states I must leave after my training program is over.

My question to you is, why should I pay for my retirement when I know as soon as my program is over, the State Department will ask me to leave this country?

A. HAMID ALIZADEH, M.D.
DOCTORS HOSPITAL
WASHINGTON, D. C.

• *There is an apparent paradox in your position—and that of thousands of alien physicians serving in residency programs in the United States under the Exchange Visitors Act. Yet, there is an explanation for what may seem to you to be an unreasonable or unfair tax. First of all, the benefits for which you are accruing eligibility under the Social Security Act (Old Age and Survivors Insurance) are not limited to citizens of the United States.*

Since you entered this country under a non-immigrant visa, just as foreign news correspondents, exchange students, and other groups in a similar visa class, you are not eligible as you correctly stated, for citizenship. But this fact has no bearing on your pos-

—*Continued on page 38*

—Continued from page 36

sible benefits. For example, if you are a citizen of one of the 16 countries with whom the United States has a reciprocal treaty arrangement in connection with Old Age and Survivors Insurance benefits, you may be eligible for benefits, even after you return to your own country.

In the event of your death occurring in the United States, or in your country within a certain period of time following your return home, your widow may be eligible to receive a lump sum survivors' benefit, depending on the reciprocal arrangement between your country and the United States. Also, your widow may be eligible to receive monthly payments for a period of time, again depending on the reciprocal agreement between the two countries. This is not automatic; your widow must make application through the American Consulate in the country in which she is residing.

Incidentally, in these cooperating countries, American citizens employed either temporarily or permanently overseas are also required to make contributions to the insurance system of the nation in which they are earning their income.

The authority for withholding Social Security payments from your income earned in the United States is in accordance with the Internal Revenue Ruling (Cumulative Bulletin 1937-1, p. 394) "The taxing provisions of the Social Security Act are applicable to services performed within the United States by aliens regardless of whether they entered this country by treaty of commerce or navigation between the United States and foreign governments, or whether they were admitted directly as employees of foreign or domestic employers."

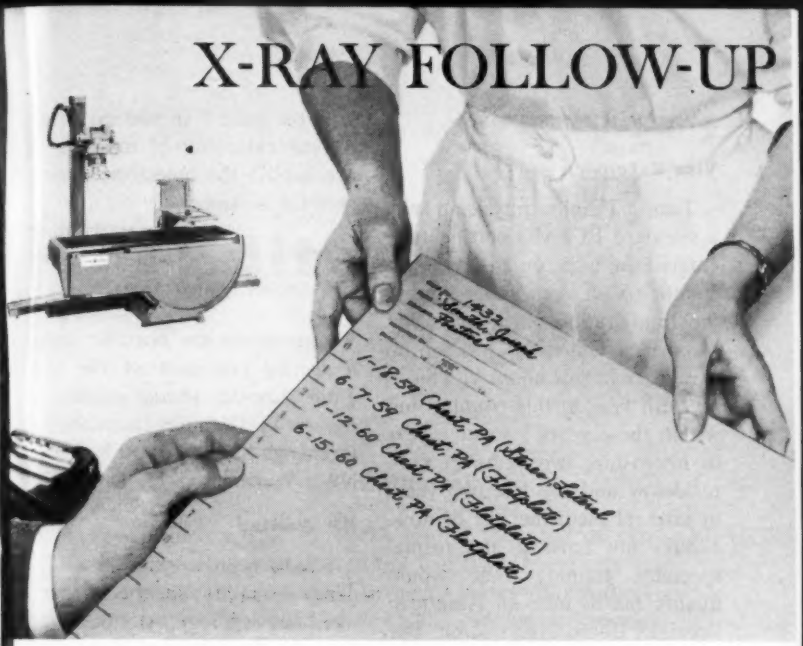
All of this is not to state categorically that there may not be an inequity in your own individual circumstance. But the laws are complicated on this subject and the application to the particular case can only be determined by the review of your individual circumstances by competent authorities.

If you will present your question in writing, addressed to the Social Security Administration office in your area, I feel confident that they will be able to provide you with more specific information as to your status. Be sure to ask for the reply in writing.

—Concluded on page 40

. . .

In pe
really
ing of
the G
tion.
cause
outpu
ably f
from
with i
cian
table
. . . o
poised
film d
to scre
limiti
chase
You c
Maxis



. . . time after time, Patrician "200" guarantees x-ray exposures exactly as you dial them

In periodic patient follow-up, you really come to appreciate the meaning of "True-to-Dial" accuracy with the G-E Patrician "200" combination. Film comparison is easier because of guaranteed consistent x-ray output. Performance holds predictably from range to range . . . even from one G-E unit to another! And with it you get so many more Patrician features: full-size 81" tilting table . . . independent tubestand . . . counterbalanced, not counterpoised, fluoroscopic screen or spot-film device . . . radiation confined to screen area by automatic shutter limiting device . . . economy of purchase and operation.

You can rent the Patrician. G-E Maxiservice® plan provides an attractive alternative to outright purchase. Included, for a convenient monthly fee, are installation, maintenance, parts, tubes, insurance, local taxes. Contact your G-E x-ray representative for details. Or just clip coupon.

Progress Is Our Most Important Product

GENERAL ELECTRIC

General Electric X-Ray Department
Milwaukee 1, Wisconsin, Room BT-61

Send me: ☐ Patrician bulletin
☐ Maxiservice bulletin

Name_____

Address _____

—*Concluded from page 38*

Visa Extension

I am a Filipino physician with a standard ECFMG certificate. I entered the U. S. on an Exchange Visitor's Visa. As I understand it, the Immigration office rules that physicians can only stay up to five years in this country. This is my fifth year in this country and within these years I spent a year of internship, two years of G.P. residency and the last two years in internal medicine. As of now, I have not finished any formal specialty training that would qualify me to take an American Specialty Board examination. The hospital where I am concluding my second year Internal Medicine residency has appointed me for the third year program, which will commence on July 1, 1961.

I personally don't want to overstay in this country beyond the requirements ruled by the Immigration Service, on the other hand, I do not want to go back home with an unfinished specialty residency program. All I ask is to finish the training that I am now in and then go home with the happy thoughts of my fruitful educational and cultural experiences I gained in this great part of the universe.

I would like to ask your office now on what I should do to get a year extension of my visa to accomplish the objectives I came here for in America.

Name withheld
at writer's request
HARRISBURG, PENNSYLVANIA

• *Extensions are possible under a special provision of the law. Your hospital should address a request to: Director,* International Exchange Service, 1910 K Street, NW., Washington 25, D. C.

RP Wanted

I have been working in a residency capacity in the Department of Pathology, Atomic Bomb Casualty Commission, here (Hiroshima). Before coming here, I had been working in pathology, Children's Hospital, Buffalo, N. Y. I received free copies of RESIDENT PHYSICIAN every month and deeply appreciated your free offering of the valuable journal. I did not notify the mailing office of RESIDENT PHYSICIAN of my change of address.

Is it possible for me to receive copies of RESIDENT PHYSICIAN every month? I would greatly appreciate any arrangement you can make.

GEN NIWAYAMA, M.D.
ATOMIC BOMB CASUALTY
COMMISSION, HIROSHIMA, JAPAN

Perrin H. Long, M.D.

Editor's Page

The Good Physician

Within a couple of weeks several thousand of you who read RESIDENT PHYSICIAN will cease being interns and become "Residents." In such a status your authority over and responsibilities for the care of sick people will be definitely increased. We might discuss certain conclusions which we have arrived at, based upon almost forty years of experience with hundreds of residents and interns, concerning the characteristics and qualities which we consider desirable in residents, and for that matter in all physicians and surgeons, no matter how senior or how junior they may be.

The order of our listing of characteristics and qualifications may be disputed by our colleagues but if so, that will be a matter of opinion; the spice of life is derived from our considerations of differing opinions.

First and foremost among the qualities which the physician of any age must possess is personal and intellectual integrity, for if he lacks honesty, his patients and our profession suffer. The Hippocratic Oath outlines the ethics and etiquette of our profession. A study of the Oath will quickly indicate that our code of ethics is based on the Graeco-Christian concepts of integrity. Our thinking and actions must be guided by

a sincere desire to be always searching for the truth. We must never accept intellectual substitutes for truth or integrity.

Secondly, we would like our resident or physician to have demonstrated beyond question that he is interested in *people,* is polite to *people,* and is thoughtful of *people.* He must not dislike the company of the sick. Otherwise, he has no business being in the profession of medicine. Furthermore, his interest, politeness, and thoughtfulness must be genuine and not simulated. We were horrified to hear a story the other day about one of our moderately distinguished colleagues, who after finishing talking in a sugary fashion on the telephone to one of his patients, turned to his secretary and said, "I hope I am not bothered by that S.O.B. again." An individual with such an attitude towards patients should withdraw (or be withdrawn) from our profession.

Thirdly, we feel that our resident should have demonstrated beyond any doubt as an intern that he has a dedicated sense of duty and a real understanding of his responsibility towards his patients. When a patient entrusts his very life to you, you have accepted a responsibility which transcends all others. Too often today, we get the impression that the practice of medicine at all levels is considered *a trade,* governed by the *rules of a trade;* that it is *a nine to five business,* and is primarily a means towards a livelihood and improved social status. Nothing can be farther from the truth, if medicine is to continue to be considered a learned profession, always observing the ethics of its code. For the physician, his duties and responsibilities towards his patients should be paramount in his social approach to life, coming even before those to his family. That's the way we were raised in our profession by our father and grandfather before us. We

feel that too often the wives of today's physicians have little knowledge or understanding of the meaning of the duties, responsibilities, and ethics of our profession. *Let our readers recall that they have subscribed to the Oath of Hippocrates.*

In fourth place we believe that a resident should have a tremendous desire to learn all that is possible about the cause, natural history, prevention and cure of disease. His curiosity should be great, and as his waking hours will be many, they should be devoted to the study of disease. Of course, while concentration at the bedside is of first importance in his education, the resident must apportion proper amounts of his time to the laboratory and for the library. They are the prime adjuncts to learning at the bedside. Remember, ours is a *learned profession.* We are not tradesmen or hucksters.

Other characteristics which must exist in or be cultivated by the resident are habits of neatness and cleanliness. It may seem odd to bring up neatness and cleanliness, but only too often the negligence relative to personal appearance of residents (and doctors) is a matter for comment. Unshaven house officers in dirty whites (or operating room suits), who wear dirty or blood encrusted shoes are not an appetizing sight, even to those whose health is robust. Furthermore, the good physician must have or develop a sense of time and punctuality. It is so discouraging to the patient when the physician is unpunctual in his visits.

The good resident has a well developed sense of loyalty towards his patients, his peers, his attendings, his interns, his nurses and other members of the medical team in which he has certain authority and responsibilities. He should be loyal to the principles and ethics of his profession and not compromise them for the sake of supposed or admitted expediencies. As patients expect to get the best possible care, the intern, the resident, the physician or surgeon should

exert all of his energy and skill to see that this is what the patient gets. *There can be no compromise.* Now in addition to being loyal, the resident (and this should apply to all doctors) must be cooperative and take his rightful place as a leader of the team. Otherwise patient care is adversely affected and the continuing education of the interns and nurses suffers. Heaven help the ward which has a secretive, say-nothing resident on duty.

And finally, but of course not least, the resident must possess a knowledge of his subject. How much? Well, certainly more than his interns and the medical students if such are on his ward. However, often a greater degree of knowledge is expected of the resident than could be anticipated from his education, training, and experience. His seniors should bear constantly in mind the residents' limitations in knowledge and experience, and not ask more of them than should be expected. By the same token, the resident should not overshoot his mark and assume responsibilities which are beyond his knowledge and competence just because he does not wish to lose status. There is no position or situation in the world in which it is more important to say, *"I don't know,"* if you really don't, than in the practice of medicine. You see, the life or welfare of your patient may well depend on your possession of a special knowledge, and if you don't have it, say so. It is the only thing to do.

Now readers who get to this point may say, well he has paragoned reality. The type he describes doesn't exist. Let your Editor say, the creed which he has outlined is one to strive to live by. In his years as a physician, he has encountered about a dozen residents who were prototypes of the creed which he has just propounded. *Working with these young men provided the most satisfying of all of our experiences in Medicine.*

What You Should Know About...

Buying a Practice

There are many exceptional bargains available to the prospective purchaser of a going practice. Here are the main things to consider in making your choice.

Wilburn L. McClure, Jr.

Outstanding opportunities for a young doctor to enter his own private practice are found among practices for sale. Yet, many of the estimated 2,000 practices up for sale each year, go for a song —or are not purchased at all.

I am not referring to used up or run down practices, or those in ghost towns or deteriorating neighborhoods. I'm talking about vital, active, growing practices which are up for sale because the seller has accepted a full-time institutional position, or is in ill health, or must change his location because of illness in his family. None of these reasons has any adverse bearing on the value of the practice.

There is, of course, an instinctive wariness on the part of most physicians concerning practices up for sale. Why is it for sale? Is the price a fair one? Would I really want someone else's patients? These are proper questions. But if proper answers are available, such a practice could well represent an exceptional opportunity.

Each month you can find practices for sale advertised in a number of medical journals. Suppose for a moment you are interested in a particular practice. How would you check further? Just what should you, the prospective buyer, look for and what do you need to evaluate the practice.

THINGS TO KNOW

- Community
- Practice
- Premises
- Space, facilities
- Personnel
- Equipment
- Business methods
- Collections, ratios
- Medical records
- Financial records, fees
- Reason for selling
- Asking price, sale terms

Community

If you're considering a house-office setup, naturally you'll want to know about schools, churches, type of neighborhood, stability and trends in employment, zoning, transportation, recreational and cultural facilities. After all, do you think you would enjoy living in the area? If not, you needn't go any further in your evaluation.

Practice

One of the first things you will want to know is the nature of the practice. How long has the seller been practicing, and has he limited his practice in any way? For instance, some internists send all lab work out and you may intend to do your own for a time. Some general practitioners do not like to see children, or won't make calls on weekends. There are a number of other such likes and dislikes.

The volume should be analyzed to see if the patient load has been dropping, increasing, or remaining at a constant level.

Other important points:

- If the physician is still living, how long will he stay on to introduce a new doctor to the patients?
- How many "competitors" have moved into the area since seller began practice and what are the possibilities of others moving in within the near future?
- Hospital affiliation. Can you expect an appointment at a nearby hospital—if so, what's the probable waiting period?

Premises

Remember, your independent appraisal of the premises must take into consideration its known location to the general public as well as present patients. Will you be buying a home-office combination or will you assume a lease that has some months to run? In either case, you must know what the property is worth, the terms and, if there's a lease, what are the terms of renewal.

Will there be an increase in the rent? What alterations will the landlord make, if such are required.

If a home-office combination is involved, you must know if the practice can be moved to another location easily if you decide to assume the practice but not purchase the real estate. In most cases this can be done if the purchaser locates nearby or gives proper notice to patients.

Space, facilities

The amount and arrangement of available space—and how you can best use it, is important. Possibly the seller has the rooms arranged to suit his mode of practice while the purchaser might desire 1) more room or 2) a rearrangement of the entire facilities.

If it is a general practice, is there room for all types of examinations for both children and adults? If you are looking at an internal medicine practice, is there room to do lab work. How about x-ray: is there room for such equipment plus a dark room? Is the waiting room large enough? Are the examining rooms large enough and do they lend themselves to an orderly system and ease of practice?

If the space and facilities are deficient or conflict with your type of practice or your personality, then you are in the wrong place.

Personnel

The purchaser should be concerned about the personnel situation. More than a vital adjunct, in many cases the physician's efficiency is keyed to his assistants' efficiency. Will the assistants stay on? The purchaser will of course want to evaluate the efficiency and need for those aides presently associated with the practice. This is especially true in a one-girl office. The personnel question is a serious one that must not be taken lightly. Having adequately-trained, properly paid, loyal personnel is a major factor in the success or failure of any practice.

Furniture, equipment

Normally there is an independent appraisal made by a local supplier of the equipment. You will want your own appraisal done. A fair rule to follow in your own evaluation is approximately 75% of original cost for items new or slightly used; items fully depreciated and still useful about 25%; those items you are not sure of, take the book value (cost, less depreciation) as shown on the seller's income tax returns.

Be sure that you are not buying items you will never use or items that are completely out of date.

Also, be cautious about pricing equipment that shows hard use or gives indications of many repairs. Sometimes it pays to find out just how much it would cost you to replace everything in the office at today's prices.

Remember, too, to list items you will need in addition to those available with the practice.

Business methods

Don't overlook the practice records and accounts. If the financial and medical reporting procedures have not been conducted efficiently, the information you require toward a fair appraisal will not be authoritative.

Collection, ratios

Did the seller send bills monthly and on time? What percentage did he collect each year of the outstanding accounts? What are the total outstanding accounts and who will collect them? Much can be told of a practice by reviewing the collection ratio of two or three years.

Do the records appear to be well kept; is the information, as recorded, understandable? This is especially important if goodwill is involved. It is always important to know just how far back the records go and how information has been recorded. Are other records available, such as lab reports and films? Also, inquire as to the number of patient records transferred in full or in part during the past year. This might tell you if the practice is steadily falling apart.

Financial records, fees

Records should be complete and up to date. When you are discussing fees, compare the fee schedule with the actual fees recorded on the cards. Has the doctor been charging what the fee schedule shows or has he been discounting or undercharging by force of habit. Many physicians raise their fees, but take months or even years putting the increase into effect.

You should be able to obtain a relative fee value scale from the local medical society or the state society. How do the fees compare? You might pay a courtesy visit on other physicians, in the same specialty, and inquire as to their fees. Much depends also on the major occupations in

ABOUT THE AUTHOR

Director of the Baltimore office of Professional Business Management, Inc., Mr. McClure is a member of the Society of Professional Business Consultants.

the area. Because of seasonal work, many physicians must adjust their fees or wait long periods of time for payment. What are the possibilities of raising the fees in the near future?

A purchaser should inquire into the past five years of the practice and determine its growth or decline. Remember, gross income figures mean little without net income and the percentage involved for expenses of the practice. If the fees were increased in the past five years, did this have an effect on the income?

Reason for selling

A few reasons why physicians sell their practices are:

1. Ill Health
2. Accepting Institutional Appointment
3. Retirement
4. Death

Each reason has an important and definite effect on the sale and transferability of the practice. If one of the first three situations prevails, it is reasonable to assume that the seller will introduce the purchaser to the patients and cause an orderly transition. But what about a practice where the physician has died? A prompt transition is necessary where a physician has deceased. It is, of course, helpful if the patients are acquainted with the purchaser either through association or through the purchaser's former private practice in the community.

Price, sale terms

The asking price, method of computing asking price and the sale contract terms should be discussed with competent authorities. Lawyers and accountants provide good information for the most part, although keep in mind that they may have little or no previous experience in such a transaction. All the caution exercised in the selection of a practice may be wasted if the advice you receive regarding its purchase is not competent, and based on previous experience in similar situations.

In a way, the list of necessary information seems imposing. Yet, if you were going into a partnership or group, you'd want all these facts plus many more—especially about other doctors in the group.

So, the more thorough your evaluation—the more likely you are to be completely satisfied with your new practice.

Buying a Practice . . .

RECENT TAX COURT DECISIONS

For . . .

Chester R. Johnson, Jr., M.D., specializes in obstetrics and gynecology. He purchased the personal property of a retiring obstetrician, the property consisting of furniture, x-ray equipment, medical supplies, and approximately 5,000 patients' charts. The charts were of value if the patients of the retiring doctor consulted Dr. Johnson, a good possibility since there were few obstetricians in the locality.

Because of the transient nature of the population, the limited type of medical practice, and the relatively brief span of years in which women are likely to bear children, Dr. Johnson and the retiring doctor agreed that each chart would be worth $1 each year for five years, or a total price of $25,000 for all the charts. This amount was included in the purchase price and was stated separately in the contract of purchase.

Dr. Johnson took a 20% depreciation deduction in his income tax return for 1956 and 20% thereafter for each of four more years. The Commissioner of Internal Revenue contended that the amounts expended for the charts was in the nature of a capital expenditure (with no definite, ascertainable life) and was not an item properly subject to annual depreciation.

However, the District Court, in a recent decision, held in favor of Dr. Johnson; i.e.; that such charts were in fact property with a definite life and used in taxpayer's medical practice, and were subject to depreciation. The court did rule, however, that 10% of the purchase price constituted goodwill ($2500) and could not be depreciated, and that the life of the charts was six years, not five years.

Against . . .

In another case the taxpayers, four doctors of medicine, purchased a medical, surgical and hospital service practice from a retiring physician. In this situation the patient subscribers paid "dues" in exchange for comprehensive health care under a contract. The contracts were terminable at will by either party upon written notice.

The contract of purchase provided for the acquisition of all of the right, title, and interest in and to the contract medical practice, including goodwill, prepaid dues, contracts with subscribers, furniture, fixtures, fittings, instruments, and equipment and all medical records, and drugs, accessories, medical and surgical supplies.

In the purchase, the four physicians allocated a part of the practice cost price to the furniture and fixtures. They considered the balance of the entire purchase price to be for the medical service contracts. They then wrote off a prorated share each year as Membership-write-off and deducted this item as an expense item from taxes.

The Government contended that the contract did not specifically allocate any part of the sales price to the contracts, and that this was an intangible capital asset without a useful life that was determinable, and because of that was incapable of being estimated with reasonable certainty, and therefore could not be subject to depreciation.

The Tax Court held that the taxpayers bought a single intangible asset consisting of 8,984 medical service contracts and this asset had no limited or determinable useful life and therefore could not be amortized over a period of years pursuant to Sec. 167 (a) of the Internal Revenue Code of 1954. (Richard M. Boe, et al 35 TC 79.)

Thus we find two taxpayers, each buying a similar type asset, each coming up with a different tax result because of the elements as set forth in the contract to purchase.

In this respect it is important to note that goodwill cannot be amortized or depreciated.

However, a restrictive covenant (an agreement not to compete) separately bargained and paid for, can be depreciated over the life of the covenant. Likewise, the value of any leasehold acquired can be amortized over the life of the lease. The cost of the furniture and equipment purchased can also be depreciated over the remaining life of the equipment. Thus, it becomes apparent that the more that can be properly allocated to these items in a contract of purchase of a practice, the lower will be your taxes, as opposed to the purchase of goodwill which does not give rise to a tax deduction.

By tracing a single subject, the author offers an example of . . . .

7 Ways to Read 5,000 Medical Journals

Saul Kuchinsky

Speculation on how to deal with the flood of medical literature can take on unduly dramatic proportions. "Eliminate the 'unnecessary' journals," serious critics thunder. "Shoot a few publishers," one has even suggested in print.

Actually there are seven well-reasoned ways for the doctor to cover the literature, without resorting to elimination or murder. Each has a special advantage, and together they are a stable approach, unaffected by the number of medical journals that may be printed in the foreseeable future.

To demonstrate their use and usefulness, we have taken a random subject, *Renal failure,* and followed its course through the seven media, searching for the most recent journal literature available at the time of this writing.

1. Index Medicus

If it is almost an axiom that the doctor who doesn't keep up with medical progress for five years is ten years behind, then it is doubly true that the searcher who doesn't make a habit of using Index Medicus leaves more medical excitement buried between paper or buckram covers than he can pry loose with all other cliche tools combined.

A little more than a year ago, I.M. became, under National Library of Medicine auspices, the major journal index in English

of medical literature, selecting monthly from among the more than 5,000 world-wide medical journals received by the National Library. Its two predecessors, Quarterly Cumulative Index Medicus, the bound-volume AMA work, and Current List of Medical Literature, the National Library index, have been discontinued.

Now for our sample subject; how do we look up *Renal failure* in I.M.? There are separate alphabetical listings of subject and author in each issue. We use the subject listing, of course, and we try to find that subject heading, in exact syntax form, which I.M. has used to list pertinent articles. Searching the August 1960 issue, we find that *Renal failure* does not appear at all in the R's. We next look for *Kidney* in the K's, find it, but see no articles beneath it on renal failure. When we examine *Kidney diseases,* however, we note, even before we start scanning its articles, the introductory cross reference: *"See also Acute renal failure."*

Now, turning to the A's, ("Acute") we have three articles under a heading we had not thought of but had been led to by a cross reference. The articles are *Acute Renal Failure in Obstetrics and Gynecology, report of 2 cases,* also *Acute Renal Failure,* also *Considerations on Acute Renal Insufficiency Post-Abortem.*

Subject headings can sometimes be a lot tougher to find. To conserve space, I.M. limits the number of its cross references, thereby straining the ingenuity of the searcher to the limit.

Finally, we have here, as elsewhere among searching media, the problem of foreign language articles. Because our first article above is in Spanish, we either latch onto a Spanish-translating friend, hire a professional translator, wait hopefully for its translated abstract to appear in the standard abstract sources, or ask our librarian to write to the Special Libraries Association Translation Center at the John Crerar Library in Chicago for a translated reprint.

ADVANTAGES: **Access to the most inclusive bibliography in current medical literature.**

2. Abstracts

There are indices also, mainly in special fields, which abstract the articles they list, and there are a few abstracts journals.

Chief among them are Abstracts of Soviet Medicine, Abstracts of World Medicine, Biological Abstracts, Cancer Chemotherapy Abstracts, Chemical Abstracts, Congenital Anomalies Literature, Dental Abstracts, Excerpta Medica, International Abstracts of Biological Sciences, International Abstracts of Surgery, International Medical Digest, International Surgical Digest, Leukemia Abstracts, Modern Medicine, Multiple Sclerosis Abstracts, Muscular Dystrophy Abstracts, Obstetrical and Gynecological Survey, Poliomyelitis Current Literature, Survey of Anesthesiology, Survey of Ophthalmology, and Urological Survey.

Searching the widely used Excerpta Medica, we find it consists of 20 separately issued sections. On the reverse side of the front cover of the July 1960 issue of the Internal Medicine section, we find that Roman numeral VII is *Urinary system,* with subdivision *Kidney* and further subdivision *Degenerative processes.* Pagination alongside the last-named heading leads to abstracts of the two articles *Acute renal failure after aortography* and *A case of renal failure following renal angiography.*

In Abstracts of World Medicine for August 1960, the Contents page near the front cover contains the heading *Urogenital system.* Here we find the article *Acute renal failure,* a review article, and, by this index's rules, not abstracted.

In International Medical Digest for July 1960, searching in front-cover listings for *Medicine* and *Pediatrics* uncovers the article *Acute renal failure.*

Abstracts abound in abstracts sections of medical journals of every type. Unfortunately they are often not indexed in their journal. An important exception is the Journal of the American Medical Association, which indexes its abstracts and identifies them in its index with the marking *ab.* In the index of the January-April (1960) volume, under heading *Kidneys* and subheading *failure,* is listed the abstract of the article *Persistence of antibiotics in blood of patients with acute renal failure.*

A third source of abstracts is the 15-volume Year Book series. In the 1959-60 volume of the

Year Book of Drug Therapy, under the index heading *Kidneys* we find the article *Renal failure due to para-aminosalicylic acid.*

ADVANTAGE: **Basic idea, without further searching, of what is in an article. For foreign-language articles, a translated abstract.**

3. Reviews

Certain journals contain only or mainly review articles. Chief among them for the doctor are Medicine, Nutrition Reviews, Pharmacological Reviews, Physiological Reviews, Quarterly Reviews (Medicine, Pediatrics, Surgery, Obstetrics and Gynecology).

In the table of contents of the May 1960 issue of Medicine is the review article *Bone disease in chronic renal failure with particular reference to osteosclerosis.*

Another review source is the 9-volume Annual Reviews, offering lengthy bibliographies at the end of these reviews of selected subjects. Annual Review of Medicine, Vol. 11, 1960, includes in its table of contents the article *Kidney disease: acute renal failure.* Other annuals titled Progress-in, Advances-in, Recent-advances-in and the like are additional review sources.

Bibliography of Medical Reviews, a paper-cover annual published by the National Library since 1956, has been culling review articles of the previous year from the general journal literature and the annuals as found in Current List of Medical Literature. Volume 4 (1959) has 3,241 entries. One of them, under the listing *Kidneys,* is *Acute renal insufficiency: its treatment.*

ADVANTAGE: **The recent literature on a subject presented as a whole.**

4. Current Contents

The unique bi-weekly periodical bearing this title is a reproduction of the tables of contents of 500 journals at the time they are published. (Index Medicus runs at least three months behind.)

To search a subject means scanning the contents of journals in which your subject is most likely to appear. An Original Article Tear Sheet Service, at a fee, mails an article posthaste. The publisher is Eugene Garfield Associates, 1122 Spring Garden St., Phila. 23, Pa.

Scanning in the August 23, 1960 issue of Current Contents, we find the article *The manage-*

ment of acute renal failure in the table of contents for the May issue of Postgraduate Medical Journal.

ADVANTAGE: **Articles listed as soon as they are published, in a single source that affords compact, continuous scanning.**

5. Audio-Digest Foundation

This nonprofit subsidiary of the California Medical Association issues bi-weekly tapes, primarily of digests of articles in 600 current journals. Fields it covers are general practice, surgery, internal medicine, obstetrics and gynecology, pediatrics, anesthesiology. Written bibliographies and six-month cumulations of these are included in the service. Tapes can be erased and re-used 10,000 times and may be played on any tape recorder which operates at 7½, 3¾ or 1⅞ inches per second. An affiliate, Pacific Magnetic Tape Equipment Co., sells recorders and varied accessories. A-D's address is 205 N. Glendale Ave., Glendale 6, California.

In the July-December 1959 printed index of tapes for Internal Medicine, we find in the R's a 25-minute tape titled *Renal insufficiency, chronic, intermittent, peritoneal lavage in treatment of.*

A new audio agency, Voice of Medicine, of Recordo-Med, Inc., 100 Central Park South, N. Y. 19, N. Y., offers a more modest curriculum at this time.

ADVANTAGE: **The busy doctor can listen while he drives, lunches, works or hobbies. A group can listen and immediately afterwards have a discussion of the topic.**

6. Special Services

A number of associations and publishers send "packages" of reprints, photostats, abstracts, microfilms, bibliographies, translations or comprehensive reports, in varying combination, to members or subscribers, free or at a fee.

The Library of the American Medical Association sends its members or journal subscribers such packages. AMA members are not charged, others must pay fifty cents. A package on renal failure contained six reprints, dated 1956-59, and four photostats, three of them dated 1960. Speed declared to be essential, they answered by return air mail, special delivery, at cost of $1

postage. Reprints had to be returned, photostats could be kept.

The Medical Documentation Service of the Library of the College of Physicians of Philadelphia, upon request, sent a bibliography of 32 articles, all written in 1960. It required one hour to compile and would have cost an individual physician $6, an organization $7.50. The bibliography could also have been supplied on individual cards and, for additional cost, photocopies or abstracts of the articles could have been supplied. Reply was by return mail. The Service, at a fee per month, also scans the 2500 journals to which it subscribes, provides information on any subject, and offers translations.

The reprint collection on clinical subjects of the American College of Surgeons has been transferred to the Memorial Library of the Texas Medical Association at Austin, Texas; package service is available to Fellows of the College only. The collection on medical and surgical history has been retained at Chicago, again for Fellows only.

The W. F. Prior Company, Hagerstown, Maryland, sends packages free to the subscribers of its looseleaf "systems."

ADVANTAGE: **The busy doctor has his searching done for him.**

7. The Medical Librarian

Every year several thousand hospital, medical school, medical society, drug house, insurance company and advertising agency librarians instruct doctors in the use of their libraries. They explain the basic techniques of literature searching, of their work, and given advance notice, they search any medical subject requested. If their schedule allows, they will keep the doctor continuously posted on the literature in his field. Most librarians keep files on the subjects they search, and in general, conscientiously perform a service for which they are professionally trained.

ADVANTAGE: **The doctor is helped, and taught to help himself, in the necessary job of literature searching.**

ABOUT THE AUTHOR

A graduate of New York University and Western Reserve University Library School, the author is medical librarian at Montefiore Hospital Library, Manhattan.

Illinois P

ONE OF A SERIES ON LEADING RESIDENCY CENTERS

Psychiatric Institute is located in the corner of Chicago's vast Medica
Center District which covers the entire lower half of aerial photo

Psychiatric Institute

Affiliated with a number of outstanding research, teaching and patient care centers, this Institute offers an unusually broad and varied training experience in AMA-approved programs for psychiatry residents.

The Illinois Psychiatric Institute is located in Chicago's Medical Center District which contains 6,600 existing hospital beds, with another 3,300 in the construction and planning stage. Private institutions, as well as those maintained by the state, county and the Veterans Administration are grouped within the district.

The Medical Center District, ten minutes from Chicago's Loop, is serviced by elevated trains, buses and expressways, and is in the center of a metropolitan area of 5 million persons.

The Institute is a 12-story, air-conditioned structure, containing 454 patient beds, resident living quarters, research facilities, administrative offices and outpatient department. A division of the state's public welfare department, it was constructed two years ago with funds made available under the Mental Health Act.

Institute is staffed by full-time medical librarian.

Serving the Institute in an advisory capacity is the Illinois Psychiatric Council, comprised of the chairmen of the departments of neuropsychiatry of the five Chicago medical schools, Michael Reese Hospital, the Psychoanalytic Institute, and the state welfare director.

The resident is assisted by the contributions of the different participating faculties, each patient floor and outpatient clinic being administered and staffed by one of the cooperating institutions.

The Institute has its own administrative, clinical, educational and research staff. The directors of the various divisions are: Dr. Lester H. Rudy, Superintendent; Dr. Jackson A. Smith, Clinical Director; Dr. Percival Bailey, Director of Research, and Dr. Jules H. Masserman, Director of Education.

Each patient floor consists of two divisions which may be utilized as an open and a closed section. In addition, there is a six-bed acute or medical treatment ward, office facilities and an activity therapy room on each floor. Patient rooms are tastefully decorated, single or double, with separate bathrooms. There are no male and female areas; both sexes are housed in adjacent rooms throughout the hospital.

Two floors, entirely devoted to research and laboratory functions, contain the most recently designed equipment for clinical diagnosis in all types of mental illness as well as that required in

behavioral, neurophysiological, biochemical and clinical research programs.

An extensive and growing Institute library, with a full-time medical librarian, contains a wide selection of periodicals and books pertaining to psychiatry and allied disciplines. Also, the University of Illinois medical library with 141,000 volumes is available to residents.

The museum contains an outstanding display of neuropathological specimens. These have proved of considerable value for house staff study purposes, including the preparation of residents for Board examinations.

An outpatient department is maintained as a separate entity, with its own staff collaborating with other schools.

Allied disciplines make possible a complete approach to patient care. Social service maintains two or three staff members on each patient floor. The nursing department personnel provide intensive care for the individual patient, and also take part in a continuous training program to assure well-trained personnel, able to perform all available prescribed techniques as indicated by the physician.

The psychology department representative on each of the patient floors, as well as in the outpatient department, provides an excellent diagnostic source in addition to performing an active role in research, group therapy and ward treatment programs. Activity therapies include recreational, occupational and vocational rehabilitation; the activity room on each floor is staffed by two qualified therapists.

The Institute has no private patients and all admissions are either for teaching or research. The patients are chosen individually and the ratio of committed to voluntary patients varies according to the type of cases desired.

All patients are the direct responsibility of the resident.

Residents make frequent use of neuropathology museum.

Each of the seven services is under the direct supervision of a full-time service chief and assistant chief who are aided by faculty members from each of the participating institutions. Instruction and consultation extends from the basic sciences to the most practical clinical problem. Each of the services and the outpatient clinic has 12 hours of supervisory time provided by outside consultants each week. The approach followed in private practice is represented by these supervisors.

The administration states: "the permanent and consulting staff includes several prominent figures in American psychiatry today. In the teaching setting they have proven to be informative and at times refreshingly controversial. They maintain close enough contact with the resident

to provide viewpoints, suggestions and stimulation that can only be acquired in an informal manner."

At least every two weeks a lecture is presented by some invited visitor. "This is further 'frosting,'" according to administrators, "that is of unpredictable value, depending upon the resident's individual interests."

Requests of the residents are given consideration when invitations are offered.

Research

In keeping with the intent of those planning the Institute, research has a place of prominence. The research staff includes representatives of the disciplines of neurophysiology, neuropathology, biochemistry, biophysics, experimental psychology and other allied basic sciences, in addition to those participating in clinical research programs which are the result of coordinated efforts of research and clinical personnel.

Research, subsidized by funds provided by the Mental Health Act, includes independent as well as diversified efforts. "It is this division of the Institute," according to the administration, "that best embodies the objective qualities that are sorely needed to transfuse current thinking about mental illness."

The three year residency program follows a general plan, although exceptions are made for those desiring to obtain qualification in child psychiatry, neurology and occasionally in full-time research or the beginning of analysis. The program as outlined is designed to provide the training needed by the psychiatrist in private practice or a general institutional setting.

The first-year is spent on the inpatient services at the Institute. Each resident is assigned 10-12 patients for whom he is totally responsible. He may follow them after discharge in the outpatient department if this is desired. For this reason, supervised outpatient experience is presented immediately.

Approximately 12 hours a week are spent in didactic courses to give a strong framework in support of clinical experiences. Courses are as follows: basic psychiatry, clinical psychiatry, introduction to therapy, psychology, social sciences, neuroanatomy, neurochemistry, neurophysiology, neuropathology, neuropharmacology and clinical neurology. In these didactic approaches the program offers its appeal to those with interests in organic psychiatry.

First year residents are aided

in their work and learning experiences by modern laboratory, demonstration and dictation equipment, and an efficient clerical and medical records staff. First year residents have the opportunity of utilizing or observing all diagnostic and therapeutic approaches including psychological testing, pneumoencephalography, use of the EEG, electroconvulsive therapy, psychotherapy, pharmacotherapy and lobotomy.

Affiliations

A part of the second year is spent on services in affiliated teaching institutions. These are Chicago State Hospital and Galesburg State Research Hospital. The resident obtains experience in ward administration, working with adolescents, on chronic wards and on treatment services. Supervision is available for the above functions as well as for the patients to be carried in individual therapy. The resident, assigned 75 patients, heads a team consisting of ward physician, social worker and nursing personnel. Allowance is made for spending one day each week at Illinois State Psychiatric Institute for lectures, seminars, and outpatients who may still be followed from the first year if desired.

In the third year, six months are spent at the Institute for Juvenile Research (in child psychiatry), municipal court, family court and the Cook County Mental Health Clinic. Advanced didactic and clinical work is given in psychoanalysis, psychosomatics, group therapies, forensic psychiatry, psychology, clinical neurology, diagnostic neurology and neuropathology. Six months are spent in the outpatient de-

Dr. Lauretta Bender presents guest lecture in Institute auditorium.

partment to conclude the training.

Certification can be obtained in Child Psychiatry by departing from the above program after two years and spending two years at the Institute for Juvenile Research and William Healy School.

Sufficient flexibility is maintained to allow deviations from the program and available extra time may be devoted to the pursuit of the resident's own interests. The numerous hospitals in the area offer unlimited opportunities for seminars and clinical presentations.

Vacation, salary

Night call is rotated among 30 residents in the program and is infrequent for any one resident.

The straight three year residency offers a stipend ranging from $4,000 to $6,000. A career residency is a five year program with two years of service at an assigned state hospital or school; the stipend in this program begins at about $7000, with salary range dependent upon individual qualifications and circumstances.

National Institute for Mental Health Fellowships are available to qualified candidates, and grants of up to $12,000 per year for training are available.

Additional benefits are 24 paid vacation days and holidays each year, and optional group health insurance. In summary, the residency program is conducted in an academically and clinically-oriented Institute. The approach is eclectic. The resident is exposed to the various present day philosophies of treatment, but he is allowed and encouraged to follow his own interests.

Further information on residency training may be obtained from Dr. Jules Masserman, Director of Education, Illinois State Psychiatric Institute, 1601 West Taylor Street, Chicago 12, Ill.

Guest Editorial

Jackson A. Smith, M.D.

Resident Fatigue

About the only time most residents show anything resembling unrestrained joy is during the last few days of their training or just before holidays when they aren't on call. Aside from these interludes, most residents may be somewhat dyspeptic and show certain other signs and symptoms which apparently relate to their position, and which may be termed "resident fatigue."

The etiology of this syndrome, "resident fatigue," cannot be related to climate, rounds, celibacy or the chief of service, although any of these factors may aggravate the condition.

When psychiatric residents are afflicted, the psychic components tend to be exaggerated; but the severity and prognosis are about the same as in other specialties. The condition is progressive, begins in the middle of the first year of residency and is most marked during the latter half of the third year.

A part of this fatigue can be traced to anorexia; "all the food in the hospital dining room tastes the same." Insomnia is another factor, resulting from the inadequate, noisy quarters; tinnitus from answering other people's calls compounds the malady.

JACKSON A. SMITH
Clinical Director
Illinois State
Psychiatric Institute

The complaints of mental origin are even more strikingly dramatic: a paranoia with a well-defined delusional system may be in evidence, i.e., "All the nurses treat me like I was a medical student." Or there may be some evidences of depersonalization: "Just what am I supposed to be, anyway?"

Nausea and even vomiting may result from purely emotional sources: "Half of the senior staff make me sick to my stomach," or, "that was about the most nauseating lecture I ever heard."

Objective signs of "resident fatigue" may be seen, and among these is irritability and apathy, especially severe before 9:00 AM and immediately after a big hospital lunch loaded with starch.

Somnolence (bordering on narcolepsy) is reported in the afternoon and this sign may reach epidemic proportions during a CPC when slides are being shown.

Somnolence or brief intervals of disorientation may also occur when the senior staff begins to discuss resident training in "the good old days when we used to really work."

Only a clinical director can appreciate how dangerous a life most residents live since there is seldom a morning that passes that one of these young physicians doesn't have a minor car accident, a flat tire or get stuck in the snow. These hazards with traffic and the elements understandably prevent the resident's arriving promptly at 8:30 AM—even when he lives in the hospital!

Periodically, some basic research is done on this disorder (usually after an outbreak of scurvy), but "resident fatigue" defies long term study—because it always ends within 24 hours after the physician starts practicing his specialty.

A **Resident Physician** MONTHLY FEATURE

Clinical Pathological Conference

Illinois State Psychiatric Institute, Chicago

This 28-year-old-woman was committed for hospitalization as mentally ill on December 8. She was brought in by her family who stated "she was irrational and not herself."

PRESENT ILLNESS: In August prior to admission this patient was felt to be religiously preoccupied, secretive and fearful of disaster. Since September, this known epileptic for 27 years had been having increasingly violent seizures. These were characterized by: no warning, a grand mal seizure of three minutes duration, and "loss of consciousness" and confusion for two hours afterward. During these two months she also appeared to her family to be irrational, extremely negativistic, at times mute and to weep hysterically. Quite recently she had been refusing her anticonvulsant medication and generally could not be controlled. She was taken to a private hospital for 12 days in November, but was not helped by psychiatric treatment.

FAMILY HISTORY AND PAST HISTORY: Both parents seemed extensively involved with the patient and recognized that they had infantilized her. The father has cardiac disease including a

evere "heart attack" two years ago. A female sibling two years younger than the patient is in good health.

The patient was the product of a normal pregnancy but a prolonged difficult labor. Forceps were used and the mother stated that it was 14 months before the "scars" disappeared. The parents noted seizure activity in the first year of life. Convulsions were noted with a high fever at approximately one year. Most of the time the seizures were controlled fairly well with medication (Dilantin and phenobarbital). She walked and talked at slightly over one year and the parents felt she was a normal baby except for the seizures.

She was an average student, had many friends and graduated from high school. She worked as a nurse's aid and contemplated marriage but felt that her seizures disrupted her plans. In recent years she was described as rather stubborn, meticulous, tended to hoard things and had food fads.

PHYSICAL EXAMINATION: Negative.

NEUROLOGICAL EXAMINATION: Negative.

MENTAL STATUS EXAMINATION: This was a slender, tall woman who at times kept her eyes closed for hours with head turned to avoid contact. On other occasions the patient appeared distant and uninvolved as though she weren't quite communicating. She had a rather vacant look and affect was very flat. Speech was often not relevant and thinking concrete. (Example: "We live out in West Park and that is where the water tower is green and blue and it's very beautiful and my niece and I go walking together; she is a bluebird in the Brownies.") Handling of proverbs was bizarre. (Example: In response to "A rolling stone collects no moss," she replied, "Well, moss can eat mothballs sometimes and they can eat moss.") Delusional material was present and she was not oriented as to time and place.

PSYCHOLOGICALS: 12/18/59—The Wechsler Adult Intelligence Scale, Rorschach, Bender-Gestalt, Koch's Block Design and Draw-a-person were administered. I.Q. 89 (marginal level) with greatest deficit in abstract reasoning. The patient can memorize and repeat eight digits forward and seven backwards, the latter a feat which few persons can accomplish. Affectivity is infantile and undifferentiated. Projective testing revealed her defenseless in the face of stimula-

LABORATORY

HEMATOLOGY: Negative

URINALYSIS: Albumin +
Bacteria +
Culture, Staphylococcus aureus

RADIOLOGY: Chest, negative
Skull x-ray (4), negative

ELECTROENCEPHALOGRAM:

12/23/59—Left temporal focus (mainly anterior temporal) activated by drowziness and light sleep.

1/15/60—Very important diffuse perturbation which is consistent with a confusional state. The reactivity of the record is poor. The general aspect of the record differs from 12/23/59.

5/6/60—Record is markedly different from the previous ones. The left temporal spike focus is not seen. Basal activity is less abnormal than on the record of 1/15/60 which was taken shortly after a seizure. However, diffuse abnormalities are present.

tion except to respond in an illogical release of poorly organized thought and inappropriate affect. The Bender-Gestalt and Koch's Block Design did not reveal organic deficit.

Hospital

HOSPITAL COURSE: The patient received Chloromycetin 250 mgm. t.i.d. for 12 days for treatment of an urinary tract infection. Repeat urine cultures were negative. Throughout hospitalization she was maintained on phenobarbital 30 mgm. t.i.d. and Dilantin 100 mgm. t.i.d.

It was noted that there was a great amount of fluctuation in this patient's withdrawal, muscular coordination and state of consciousness. One moment she would appear ataxic and the next moment would be walking without any obvious deficit. This would vary in a matter of minutes.

Dec. 26-30, 1959: Patient fell down several times, hitting her head without losing consciousness.

Jan. 2, 1960: Questionable lateral nystagmus. Eye grounds negative. Weakness, lethargy and complaints of dizziness coinciding with fluctuation in emotional state.

Jan.-Feb. 1960: Patient is

negativistic, refuses to eat, voiding in bed, smiling inappropriately and when getting up from chair appears to lose her balance. On one occasion was noted to have acute urinary retention.

March 1960: Patient refuses to stand by herself long enough to get an accurate weight reading. Poking herself with food utensils when told she could eat if she tried, and rubbing her head in the food.

April - May, 1960: Management continues to be difficult. She is incontinent, makes no effort to eat, sometimes tube feeding is necessary. She falls frequently.

On June 24, 1960, she was transferred to another hospital and in addition to the above mentioned anti-convulsants, received Stelazine 2 mgm. t.i.d. for 10 days. At times she would eat with urging but generally had to be spoon-fed. In early July she was observed to be very untidy, withdrawn, incontinent and had six seizures in a single day. Nutritional status continued to deteriorate and on July 8, 1960 she was transferred to an infirmary, appearing stuporous and malnourished on admission. She responded briefly to a high calorie diet, parenteral fluids and vitamins but again became very withdrawn and required complete nursing care. She expired quite suddenly on July 27, 1960. An autopsy was performed.

Discussion

CLINICAL DISCUSSANT, DR. R. DRYE: From the beginning of her course in this hospital, patient presented a diagnostic and management problem. She had been chosen for admission, with a known history of epilepsy, as an exercise in differential diagnosis, primarily between Chronic Brain Syndrome associated with convulsive disorder 009-550 and Schizophrenic Reaction, catatonic type 000-x23.

First, however, I shall summarize the clinical findings. The patient gave a history, confirmed by the family, of having had seizures which were well controlled by medication until immediately before the present admission. Even those which occurred were often momentary, and accompanied by "dizziness" rather than loss of consciousness. These episodes could be correlated with immediate ward situations.

During the first two months of the patient's hospitalization she fluctuated between bedridden helplessness and the ability to walk to an office with the psy-

chologist, unassisted. Even when she remained in her bed and was eating poorly, no weakness, consistent incoordination, or changes on neurological examinations in general could be demonstrated.

Suspicion

Psychologically, the patient at first appeared to have some memory defect, but rapidly learned her way around the ward and never forgot an episode after her admission. This was difficult to evaluate since she regarded her doctor and staff with suspicion, and initially presented some delusions about a secret with her sister as a reason for not saying more. Once this initial suspiciousness passed, she would become very agreeable to a staff member and then either present them with increasing demands for care, e.g., "take me to the bathroom," or if the usual accidents of vacations, shift changes, or illness made them unavailable, refuse to talk to them when they returned.

Initially, she cared for her appearance, but after the second month, more usually stayed in pajamas with no makeup. Her expression changed from friendly to preoccupied to (after a closed ward transfer) a tightly-closed mask, which she would occasionally open when she wanted to observe the visitor. Laughter was inappropriate throughout, although the staff often had the feeling that the patient was about to laugh at them when she had succeeded in being completely passively hostile.

Anger, except for one slap at her mother and a few "bumps" into nursing personnel, was always expressed by falling, hurting herself, or in the last few months, by well-aimed incontinence. The patient, at first verbally and later by refusing to eat or go to the bathroom, expressed many demands for infant-type care from the staff. During the last two months she would frequently scream unintelligibly while alone. Whether in bed or the day room, there were bizarre choreiform arm, leg and facial movements which would suddenly vanish.

Infantile

The past history of seizure has been mentioned. Psychologically, this patient had remained dependent on her parents, her only employment an occasional baby-sitting job at her sisters. Even this had been challenged at home, initiating a prolonged period of retreating to her room. It seems to have been this rather than

seizures which caused the family to seek hospitalization.

In summary, the patient presented a demanding, infantile woman whose ataxias, choreas and seizures had a highly variable pattern, closely correlated with ward situations, but with a tendency to more and more withdrawal and an increasing requirement of nursing care for basic functions.

Psychological testing, the mental status, neurological examination and skull x-rays revealed no evidence for a brain syndrome. The EEG remained abnormal, with fluctuating changes.

Acute reactions

At the time of admission then, this patient could be considered as having a diagnosis of 930-x08, grand and petit mal epilepsy justified by history. Her seizures were complicated by either conscious dramatic or conversion symptoms, so that the diagnosis of acute undifferentiated schizophrenic reaction with conversion features, seemed most appropriate.

As the patient's illness progressed, she became as so often happens with acute schizophrenic reactions, more classically catatonic and at time of transfer, this was the clinical impression.

At the same time, however, could something else have been going on? Had her psychological decompensation been triggered not only by the family interplay but by intracranial pathology? I am inclined to think not. The patient's growing helplessness could be very well summarized under negativism and at no time did we feel out of contact with her, although a slight muscle twitching was all that presented. The patient's death remains to be explained.

She left this hospital and was apparently first maintained elsewhere in good general nutrition. It would be expected that a number of seizures might have predisposed her to aspiration and long bedrest to pneumonia. In the absence of a detailed description of her final seizures, I find no further evidence for an intracranial cause of death.

CLINICAL DIAGNOSIS: 1) Schizophrenic Reaction, catatonic type. 2) Epilepsy, grand and petit mal, uncontrolled. 3) Pneumonia.

CLINICAL COMMENT, DR. J. MASSERMAN: Ferenczi and Holos long ago pointed out that even in leutic general paresis the clinical grandiosity, explosive hostility, and delusional confusions are as much a compensa-

Figure 1. The left Ammon's horn, Sommer's sector, appearing shrunken, with loss of nerve cells and moderate increase of glia nuclei.

tion for the patient's sense of progressive disintegration as they are a direct result of the CNS lesions themselves. So also, in every case of cerebral defect, we must expect corresponding episodes of anxiety and panic, defensive over-reactions in the form of bizarre self-assertions and flights into fantasy — or, when these fail, retreats into negativism and catatonic oblivion.

This patient, handicapped since birth by what was probably a neonate cerebral injury and living in covert terror of unpredictable seizures, apparently utilized all forms of "ego-defense:" meticulous preoccupations with detail as a means of precarious control; avoidance of human contacts (including career and marriage) for fear of rejection, and when finally disoriented and depersonalized by combinations of inner lesion and outer threat, immersion in "primary - process," symbolism and autistic behavior.

Bailey, Penfield and Rasmussen and others have shown that lesions of the left temporal tip are particularly likely to be associated with "psychomotor" distortions of the sensorium, and body - image, with substitutive paramnesias, schizoid hallucinations and fugue-like automatism.

The patient's final anorexia and inanition may also indicate an ascending reticular system impairment. As is always true, then, this patient can be understood only from a comprehensive physio-psychologic (i.e., a total behavioral) standpoint; however, since I have not personally witnessed either her behavior or its somatic substrate, any more specific formulation would be only further speculation based on incidental hearsay.

PATHOLOGICAL FINDINGS, DR. GARRIDO: Exclusive of the brain, the findings were of moderate congestion of the lungs, liver, kidneys and spleen.

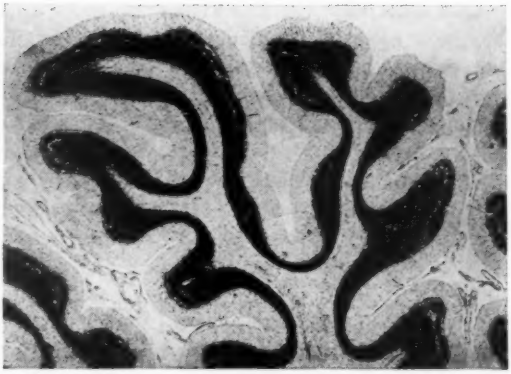


Figure 2. Section of Cerebellum showing practically complete disappearance of Purkinje cells and marked proliferation of Bergman glia cells.

DR. HABERLAND: On macroscopic examination the left Ammon's horn is somewhat smaller than the right. The medullary core of the L. hippocampal gyrus is thinner than the right one. The folia of the quadrangular and superior lobules are moderately atrophic.

Microscopic examination revealed: (1) In the left Ammon's horn and temporal lobe, the Sommer's sector is shrunken and reveals complete loss of nerve cells with moderate increase of glia nuclei. There is a mild gliosis in the white substance. (2) Medulla, pons and frontal, parietal and occipital cortex show a mild diffuse gliosis. (3) Cerebellum—There is a diffuse atrophy of the cerebellar folia involving the vernia and hemispheres. The cortex is reduced to ⅔ of its normal width. There is practically complete disappearance of Purkinje cells in the vermis and hemispheres. Glia cells are markedly increased in number and size. There is a moderate to marked glia proliferation in the white matter. A few perivascular infiltrations are detectable in the cerebellar substance, too.

ANATOMICAL DIAGNOSES: 1) Pulmonary, hepatic, renal and splenic congestion. 2) Sclerosis of left Ammon's horn. 3) Diffuse cortical cerebellar degeneration. 4) Diffuse moderate gliosis in cerebral white substance and brain stem.

QUESTION: Anatomically, was there anything adequate to explain the rather sudden death?

ANSWER: No.

QUESTION: What caused the cerebellar degeneration?

DR. PERCIVAL BAILEY: This has been reported with Dilantin but only with much larger dosages than this patient received. It cannot be the result of frequent seizures.

QUESTION: How long would a process likes this take?

DR. BAILEY: The degeneration probably took weeks or months.

DR. HABERLAND: Concerning the clinicopathological relationship, the following can be mentioned:

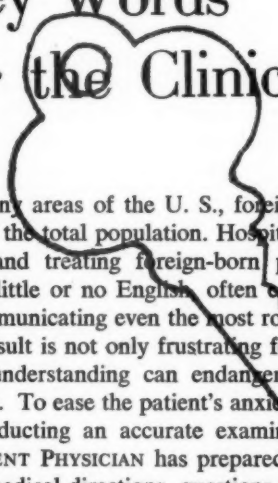
(1) The EEG revealed a left temporal epileptic focus. The pathological examination disclosed Ammon's horn sclerosis on the same side. The occurrence of Ammon's horn sclerosis in epilepsy is well known and its possible epileptogenic role in temporal lobe epilepsy is discussed in the literature. Furthermore, the Ammon's horn belongs to the rhinencephalon and the importance of this structure in the psychic manifestations of epileptic seizures and in the regulation of behavior is accepted.

(2) The diffuse cerebellar degeneration explains the patient's "weakness," ataxia involving the upper and lower extremities and gait disturbance. It may be assumed that the cerebellar disease served as an important factor in her passive negativistic attitude.

(3) The pathological changes of diffuse gliosis in the brain stem and cerebral white substance, are commonly found in chronic epileptic cases.

"It happens quite frequently whenever I try to explain what their insurance doesn't cover."

Key Words for the Clinic



In many areas of the U. S., foreign-born comprise a large part of the total population. Hospital physicians when examining and treating foreign-born patients, many of whom speak little or no English, often encounter serious difficulty in communicating even the most routine request or direction. The result is not only frustrating for doctor and patient, but a misunderstanding can endanger the proper care of the patient. To ease the patient's anxiety and assist the physician in conducting an accurate examination and history-taking, RESIDENT PHYSICIAN has prepared this guide to commonly-used medical directions, questions and answers, with translations into various foreign languages.

Using the language guide

Keep this language guide open in front of you while attending your patient. If a word doesn't seem to be understood, repeat it a few times slowly; vary the pronunciation slightly until the patient indicates his comprehension. The fact that you are trying to speak to him in his native language will cause your patient to be more relaxed and responsive. Grateful for your effort, he will be anxious to do everything he can to comprehend and convey accurate, precise information.

FOR EXAMINATION OF

Polish-Speaking Patients

In the Polish translation that follows, you will find no written Polish. Instead, the pronunciation of the Polish equivalent of each English word is indicated by a manufactured word in English. By saying the strange-looking word formations aloud (just as you would if they were real English words), you will approximate the sound of the Polish (or perhaps it would be more accurate to say you will be in the general vicinity of the correct Polish pronunciation.)

Remember, there are many Polish sounds which have no equivalent in English. On many words you will be "close, but not quite." However, the purpose of this translation is not to make you a linguist, but simply to give you a concise and handy *pronunciation guide* by which you may more easily communicate with the foreign-born patient. If we were to list all the rules of pronunciation along with the written Polish, this guide would undoubtedly help you to a more accurate pronunciation—but at the same time it would be so cumbersome and technical as to defeat its original purpose of being quick and easy to use during an examination or history of your patient. Incidentally, we do not use the standard phonetic alphabet since few individuals can *sight read* phonetics.

Basic rule of pronunciation

g is always pronounced hard as in *go, give,* never as g in ginger.

Anatomical terms

head	glaw-vah	neck	sheeyah
eyes	awchee	chest	klahtah pee-air-showvah
ears	ooshee	heart	sehrt-seh
nose	nawz	lungs	ploo-tsah
mouth	oostah	shoulders	bar-kee

teeth	zahmbee	back	pletsee
tongue	yehnzek	arm	rahm-yeh
throat	gardlaw	bladder	pan-kash
finger	pahlats	stomach	shahlon-doc
legs	no-gee	rectum	kishah awd-kawddovah
feet	stawpee	buttocks	tilleck
hands	reh-see	womb	mah-chitzah

Directions to patients

do as I do	rawbich toe so ya rawbyeh
relax	awdprehshich sheh
relax more	vyehcheh sheh awdprehshich
open your mouth	awdvawshich oostah
open your eyes	awdvawshich awchee
breathe deeply	awdickach glehboko
breathe through your mouth	awdickach pshaz oostah
hold your breath	zatsheemach awdech
push	puhnawch nahpnawch sheh
cough	kahshlach
please don't move	prawsheh sheh nyeh rooshach

Courtesy phrases

Good morning, Sir	jen dawbry pahnue
Good evening, Madam	dawbry v-yetshur
Good night	dawbrahnawts
Please	prawsheh
Thank you	jenk-you-eh
Please sit down	prawsheh you-sheeshch
How are you?	yahk shee chew-yehchee
Very well thanks	bardzaw dawbr-jeh jenk-you-eh
May I help you	chee mow-geh pawmuts
Do you understand	rawzumyesh
Pardon me	pshahprahshahm
Very good	bardzaw dawbr-jeh
Today	chishay
Tomorrow	yewtro
Yesterday	vuhchoray

General questions

do you feel sick	chee chew-yehcheh sheh kor-rim
do you have pain	chee mahcheh booleh
—much pain	—awstreh booleh
—mild pain	—slahbeh booleh
where	guhjeh
here	tootay
when	k'yaidee
how many years	illeh latt
how many days	illeh'dnee
how many hours	illeh gawjin
how many times	illeh rahzy
where were you born	guhjeh uhrawdzony
how old are you	illeh mahcheh latt

Diseases

measles	awdra
scarlet fever	shcarlahteena
chicken pox	vyechna awspah
small pox	awspah
pneumonia	zahpahlenyeh plootz
typhoid fever	tyfuss
enteritis	zahpahlenyeh kishehk
U.R.I.	zahpahlenyeh goornych drog awdehchowich

Systemic inquiry

Head	
trauma	oodehshenee
unconscious	nyepsheetomnee
did you faint	chee m'dleh-lish-cheh
are you dizzy	chee mahcheh zavrawty glaw-vee
headache	bull glaw-vee
Eyes	
sight	vzrawk
clear vision	virahshnee awbrass
near	bleesko
far	dahlehko

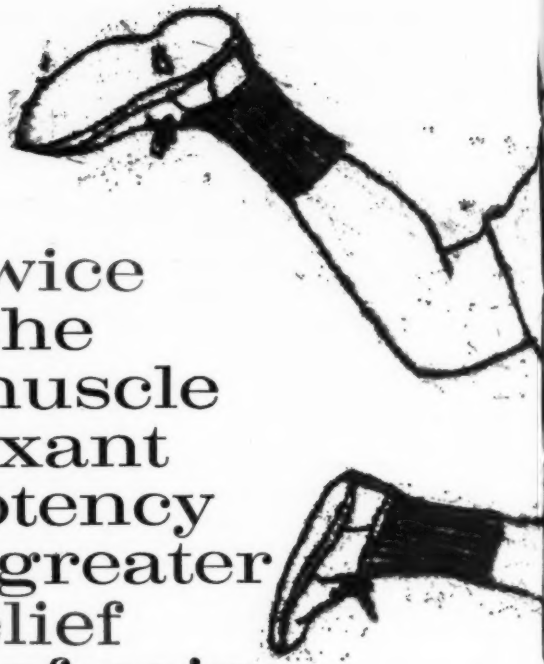
Ears	
he is deaf	on yest glookee
noise in the ears	shumm vuh ooshahk
Nose	
coryza	kahtar
did you have a nose bleed	chee mahcheh krah-vah vyen yeh nawsah
Throat	
do you have frequent sore throat	chee macheh chensteh booleh gardlah

Cardio-respiratory

do you tire easily	chee lehko oolehgahcheh smehchenyoo
are you short of breath	chee brahkooyeh vahm awdekoo
does your heart beat fast	chee mahcheh pchee-speeyay-shawnay bicheh sersah
do your feet swell	chee pooknaw no-gee
do you have pain in the chest	chee mahcheh booleh vuh plootzahk
sharp pain	awstree bull
dull pain	tehpee bull
when you breathe	pchee awdichahnyoo
do you cough	chee kashlehcheh
do you spit	chee sploovahcheh
sputum	puhlvachinah
bloody sputum	puhlvachinah zuh kriv-yone
have you lost weight	chee strachlishcheh nah vah-zeh
does someone in your family have a cough	chee kuhtahsh zuh rojinee kashlahl

Gastrointestinal

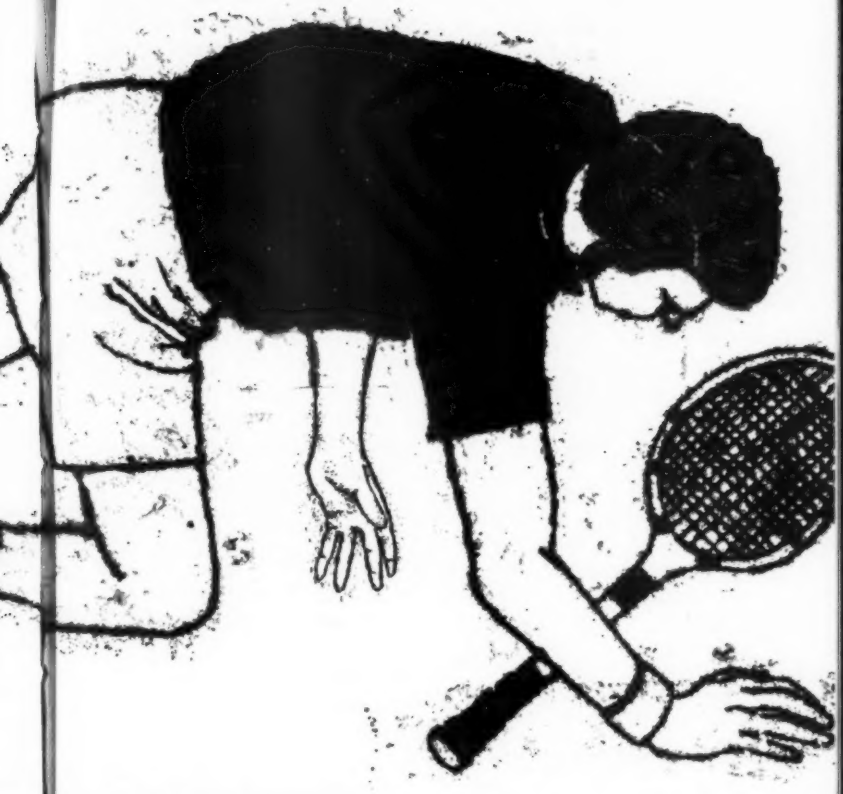
do you have a good appetite	chee mahcheh dawbry apehtit
do you have a poor appetite	chee nyeh macheh apehtit
are you nauseated	chee chee-ehcheh vimee-awtovach
were you nauseated	chee k'cheh-lishcheh vimee-awtovach



twice
the
muscle
relaxant
potency
for greater
relief
of pain
and spasm

NEW PARAFON F

Combining a superior skeletal muscle relaxant[1-3] with a preferred musculoskele
tal analgesic,[4,5] *new* PARAFON FORTE rapidly relieves *both* stiffness and associate
pain of strains or sprains resulting from trauma or too-vigorous, unaccustome
exertion. PARAFON FORTE facilitates recovery by improving function. PARAFO
FORTE is equally effective in other musculoskeletal disorders, such as myositis
whiplash injuries, low back pain, and fibrositis. Side effects are rare, almost
never require discontinuation of therapy.



FORTE

PARAFLEX® Chlorzoxazone 250 mg.
TYLENOL® Acetaminophen 300 mg.

Dosage: Two tablets q.i.d. *Supplied:* Scored, light green tablets, imprinted "McNEIL," in bottles of 50.

References: (1) Settel, E.: Clin. Med. *6*:1373, 1959. (2) Peak, W. P., and Smith, P. T.: Penn. Med. J. *61*:833, 1960. (3) Mayle, F. C.; Sullivan, P. D., and Auth, T. L.: Med. Ann. D. C. *28*:499, 1959. (4) Roth, J. L. A.: Med. Clin. N. Amer. *41*:1517, 1957. (5) Batterman, R. C., and Grossman, A. J.: J.A.M.A. *159*:1619 (Dec. 24) 1955.

U.S. Patent No. 2,895,877

374C61

McNEIL LABORATORIES, INC.
Fort Washington, Pa.

McNEIL

do you vomit	chee vimee-awtehyecheh
do you have diarrhea	chee mahcheh roz-vall-nyeh-nyeh
are you constipated	chee mahcheh zahtvard-jenyeh
did you have a B.M. today	chee mee-elishcheh jishay stawlets
feces	
black	charnee
white	beeyellee
yellow	shuhltee
brown	brawnsovee
bloody	krah-vah-vee
do you have cramps	chee mahcheh koorcheh
after meals	po yedzenyew
before meals	pshed yehjenyem
did you take a laxative	chee brawlishcheh nah psheh-chish-chehnyee
did you take castor-oil	chee brawlishcheh olay reetseenovee

Genitourinary

urine	mawch
do you get up at night to urinate	chee viztayecheh vuh nawchy awdahvahch mawch
does it burn	chee p'yecheh
chills	dreshcheh
fever	guh-rahnch-kah

Obstetrics and gynecology

at what age did you begin to menstruate	keeyaidee mee-elishcheh p-yairvshah menstrooats-yeh
How many days do you flow	yahk d'loogaw menstrooyetsee
1 to 10	roz, d'vah, cheh, shteveh, pee-ench, sheshch, shedem, aw-shum, jev-ench jeshunsh
do you have a discharge	chee mahcheh ooplahvee
when was your last menstrual period	keeyaidee awstaht-neo mee-elishcheh menstrooyets-yeh
are you pregnant	yes-tesh-tschee vuh kee-ah-shee

do you have pain with your period	chee mahcheh booleh podtshohs menstrooats-yeh
how many times have you been pregnant	illeh rahzee beelishcheh vuh kee-ah-shee
how many children have you had	illeh mee-lishcheh jet-shee
how much did the largest weigh at birth	yahkah nay-vyenkshah vahgah beelah p'chee oorawzenyoo
what was the duration of labor	yahk d'loogaw truhvahlee booleh porawdo-veh

Pediatrics

was there any trouble with the child's delivery	chee pawruhd bill skawm-pleekahvanee
how are the child's stools	yahkee yest jets-kah stawlets
—constipated	—zawt-vahrd-shawnee
—diarrhea	—roz-vall-yony
—how many a day	—illeh rahzee jenyeh
does the child eat well	chee jeh-kah yeh dawbr-jeh
any vomiting	chee vimee-awtoyetsheh
does the child turn blue	chee jeh-kah sheen-yieyeh
does the child seem tired	chee jeh-kah veeglondah smenchawneh
does it hurt	chee bowlyee
it won't hurt	taw neh ben-jeh bowlech
it will be over in a minute	taw skonchee shieh tsa chvilleh
do you want a piece of candy	cheesh tsookee-airkuh
did you take the temperature	chee mee-eshy-lesh-shee gorahnchkuh
what was the temperature	yahkah gorahnchkah
what a big handsome boy	yahkee lahd-nee klawpuk
what a beautiful little girl	yahkah schitshnah jeff-chinkah
baby	nee-maw-vleh
good	dawbsheh

History of Neurological Surgery:

A RESIDENT'S VIEW

A brief review of the men and achievements which have contributed to the development of this expanding surgical specialty.

Arjun D. Sehgal, M.B., B.S.

The picture of ancient neurosurgery gained from viewing old trepanned skulls is both enlightening and impressive. In fact, the long dormant interest in this specialty was re-awakened with the discovery of ancient trepanned skulls in Peru, France, Great Britain, Denmark, Germany, Sweden, Austria, Poland, Italy, Russia, Spain, Portugal and India, during the mid-1800's.

Examination of the skulls revealed holes made with the trephine were single or multiple, oval or circular, and from four to fourteen centimeters in diameter. Every possible location of the skull was trepanned. After seeing a number of the skulls and reading descriptions of others, I believe that those ancient surgeons, with their crude instruments of stone and wood, were manually

the equals of present-day neurologic surgeons who have modern equipment such as the Bannel drill, the Hudson drill, craniotomes, and electric drills.

Mystery

Why trepanation was done is still a mystery. Possible explanations are that it was based on a superstition, or that it was a religious or social ritual, or that it was done for medical therapeusis. The idea has been prevalent that the holes were made to allow spirits, supernatural elements, or evils to escape from the head. Such things might have been considered by primitive neurosurgeons as responsible for convulsions, idiocy, insanity, chronic headaches, head injuries, and unconsciousness. Although the actual purpose remains a secret, modern neurologic surgery is indebted to those ancient surgeons for the inspiration that has come down the years to us from their work.

The first trepanation done in North America might also have been advocated earlier, but the procedure was not well recognized until after the reports of Squier and Broca (1824-1880). Trepanation was used all over the world in the early part of the twentieth century for various conditions such as neuralgia, migraine, psychosis, arachnoiditis, hematoma, and depressed fractures.

Papyrus

Because of the advanced civilization along the banks of the Euphrates and Nile rivers, the Babylonians and Egyptians were the first to be appraised for their neurosurgical work. In 1862 a papyrus, recovered by Edwin Smith, a British official, from Mustafa Aga in Thebes, contained reports of studies of the head, the neck, and the spinal column. In summary, it was stated that the membranes are responsible for convulsions, and the brain controls the movements of the body. The relationship of the brain to the opposite side of the body was explained, as were spinal cord paraplegia and disturbances of sphincter function. The treatments most commonly advocated were honey, meat applied locally, and trepanation.

Hippocrates trepanned the skull for epilepsy, blindness, and headache. The Greek physicians had accurate knowledge of the middle meningeal artery and knew the danger of trepanation over suture lines and over the meningeal artery. Subdural, epidural, and cerebral hematomas

after eleven million treatment courses*

through the years... consistently broad antibacterial action against urinary tract pathogens

"It was interesting to observe that nitrofurantoin [FURADANTIN] showed a consistent in vitro effectiveness against the bacteria tested throughout the four year period, thus revealing negligible development of bacterial resistance, if any, through the years."[1]

*Conservative estimate based on the clinical use of FURADANTIN tablets and Oral Suspension since 1953.

consistently broad antibacterial action

...was given continuously and safely for as long as three years."[2]

Jetliff, C. R., et al.: Antibiot. Chemother. (Wash.) *10*:694, 1960.
Lippman, R. W., et al.: J. Urol., Balt. *80*:77, 1958.

Furadantin®

brand of nitrofurantoin

rapid, safe control of infection throughout the urinary system

EATON LABORATORIES, Division of The Norwich Pharmacal Company NORWICH, NEW YORK

were poorly understood by them, but cases were reported.

Infection

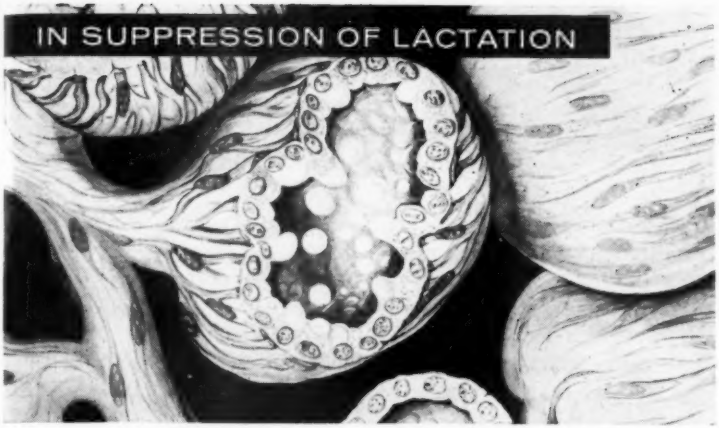
In the Middle Ages (476 to 1453) progress in neurosurgery ceased, the writings from the Middle East being the source of knowledge of neurosurgery. Infection was the most common and most important complication hindering progress. Nevertheless, surgeons like Alkazar trepanned, and evaluated bleeding not only outside of the brain but also within the brain matter. An important obstacle was lack of anesthetic agents. However, a case was reported in India, in 927 A.D.: surgeons operated upon the King of Dhar after inducing anesthesia by using a drug called "samohine;" they opened the skull, removed the tumor, closed the skull, and stitched the wound. Another drug was used to revive the king.

Until the end of the Middle Ages no fundamental advancement could be made in neurosurgery because of the need for better knowledge of anatomy, physiology, and pathology of the brain and spinal cord. The anatomic information left by Hippocrates and Galen was superficial, and insufficient to form a sound basis on which neurologic surgery could be established.

Discoveries

After the Middle Ages, many new ideas contributed to the development of neurologic surgery; Pasteur's and Koch's ideas about bacteria, Lister's methods for the control of infection, Vesalius's descriptions of the anatomy of the brain and of the ventricular system, Eustachius's ideas about cranial nerves, Van Bregman's idea of papilledema after the development of ophthalmology and the use of the ophthalmoscope, Roentgen's discovery of x-rays in 1896, and the Curies' discovery of radium in 1898, together with the work of many known neuro-

ABOUT THE AUTHOR Following his medical undergraduate training in Indore, India, in 1957, the author came to the U.S. for a rotating internship and a year of residency training in general surgery at Evangelical Deaconess Hospital, Cleveland, Ohio. Currently he is in his second year of neurological surgery under a fellowship at Cleveland Clinic Foundation and the Frank E. Bunts Educational Institute, Cleveland, Ohio.



Structure of secreting mammary gland. Secretion from the free ends of the alveolar cells passes into the lumen and is ejected by contraction of the myoepithelial cells surrounding the alveoli.

Vallestril®

brand of methallenestril

- gives "excellent" control of lactation
- relieves pain and engorgement
- reduces therapeutic complications

VALLESTRIL, with its major activity in suppressing lactation and lesser action on the endometrium, offers distinct advantages whenever suppression of lactation is indicated or desired.

- The lochia is not prolonged.
- Normal involution of the uterus is not inhibited.
- Reengorgement is uncommon.
- Withdrawal bleeding is rare.
- Nausea or toxic symptoms are seldom, if ever, attributable to the drug.

These characteristics distinguish Vallestril as a singularly safe and effective estrogenic agent, particularly free from toxicity and post-therapeutic complications.

For suppression of lactation:

The recommended dosage of Vallestril is two 20-mg. tablets daily for five days, begun as soon as possible after delivery. Vallestril is supplied as uncoated, unscored tablets of 20 mg. (and also as uncoated, scored tablets of 3 mg. for the relief of symptoms of the menopause).

G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS
Research in the Service of Medicine

surgeons, set the stage for the development of better neurosurgery.

It is impossible to point to any one discovery and to say that it was fundamental in the further development of neurologic surgery, for modern neurosurgery resulted from the combined efforts of many scientists working throughout the world.

To make this complicated and difficult subject simpler and clearer to some extent, I shall mention a few of the neurologic surgeons who have contributed to this specialty during the last seventy-five years:

Macewen lent his name to the differential percussion note of the skull which occurs when the cerebral ventricles are dilated.

Sir Victor Horsley, the father of neurosurgery in England, is remembered for his various technics, including the use of bone wax to control bleeding in the operative field.

Krause, in Germany, showed the transfrontal approach to the pituitary and the intradural approach to the gasserian ganglion.

Cushing, father of neurosurgery in America, did pioneer work in neurosurgery; he used Bovie's instrument for electrocoagulation to control bleeding.

Among Dandy's contributions was the technic of using pneumoencephalography and ventriculography as diagnostic aids to locate lesions of the central nervous system, and the marvelous investigations and descriptions of epilepsy and of motor disorders by Horsley, Cones, Wilson, Bucy, Foerster, Berger, Penfield, Cooper, Jackson, Ferrier, Meyers and Jefferson made the treatment of these conditions much easier.

Pain

Surgical relief of intractable pain challenged the neurologic surgeons. In 1886, Dana suggested posterior rhizotomy, and since then this operation has been the treatment for intractable pain. Frazier developed this operation in America, and Foerster in Europe. Cordotomy for relief of pain, first done on man by Martin in 1911 as a result of the investigations of Spiller, was superior to the analgesic treatment that was advocated at that time for pain syndrome. Peets' recognition of motor root and Frazier's section of the posterior sensory root for the relief of tic douloureux, and later the decompression operation advocated by Taarnhoj were boons to the patients who were suffering from trigeminal neuralgia.

in SHOCK surgery • trauma • allergy • infection

when only corticosteroids can give the desired results

- mg. for mg. the most active steroid—Injection DECADRON® Phosphate is ready for immediate use—no reconstitution.
- in true solution—Injection DECADRON Phosphate flows readily even through a small-bore needle.
- dramatic response in minutes, I.M. or I.V.—Injection DECADRON Phosphate may be injected as rapidly as desired.

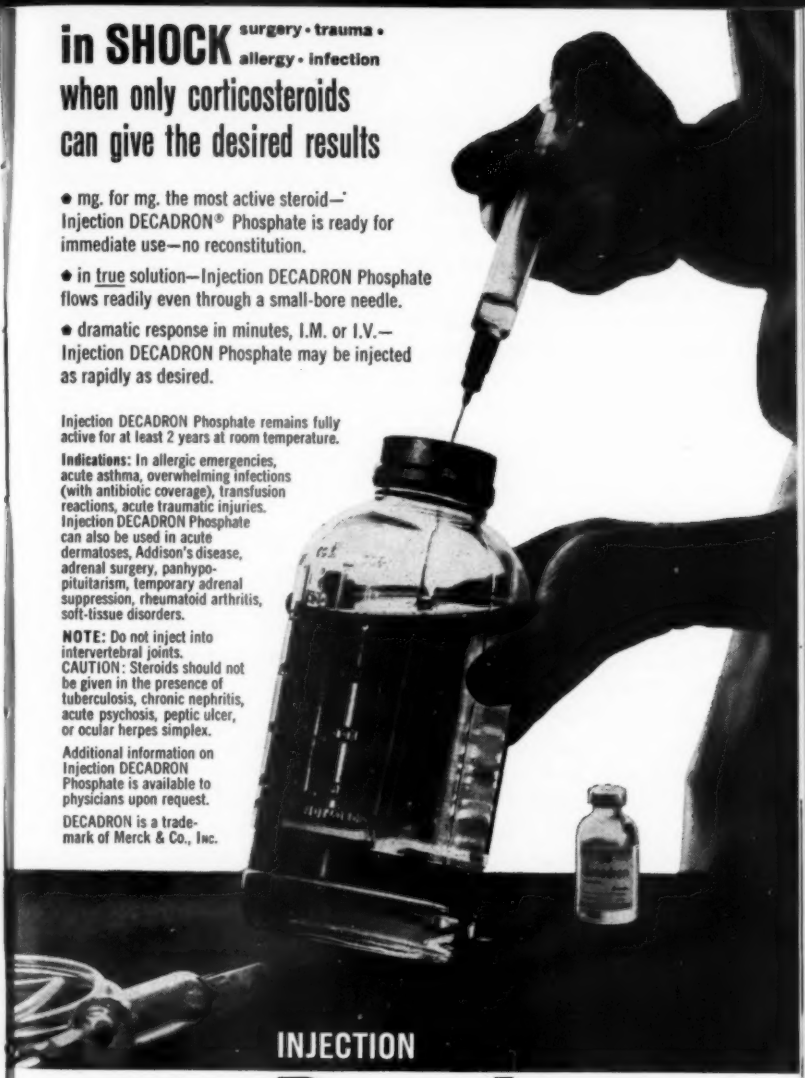
Injection DECADRON Phosphate remains fully active for at least 2 years at room temperature.

Indications: In allergic emergencies, acute asthma, overwhelming infections (with antibiotic coverage), transfusion reactions, acute traumatic injuries. Injection DECADRON Phosphate can also be used in acute dermatoses, Addison's disease, adrenal surgery, panhypopituitarism, temporary adrenal suppression, rheumatoid arthritis, soft-tissue disorders.

NOTE: Do not inject into intervertebral joints.
CAUTION: Steroids should not be given in the presence of tuberculosis, chronic nephritis, acute psychosis, peptic ulcer, or ocular herpes simplex.

Additional information on Injection DECADRON Phosphate is available to physicians upon request.

DECADRON is a trademark of Merck & Co., Inc.



INJECTION

THE DIRECT APPROACH to corticosteroid benefits

Decadron® PHOSPHATE

DEXAMETHASONE 21-PHOSPHATE

MERCK SHARP & DOHME • Division of Merck & Co., Inc., West Point, Pa.

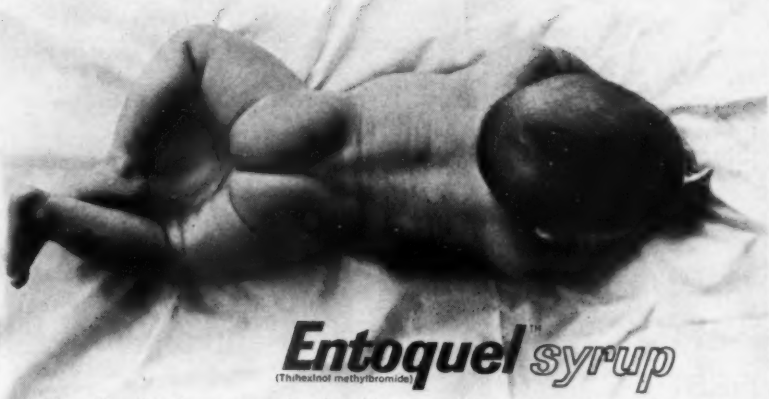
In the treatment of protruded disk, credit cannot be given to one man. Virchow, in 1857, accurately described a protruded disk, but it was not until 1934 that Mixter and Barr established the syndrome. Later the introduction of myelography and discography made surgical treatment so easy that neurologic surgeons undertook more laminectomies than orthopedic surgeons, whose knowledge of the spine was concentrated on the bony structures. The day is coming when neurologic surgeons will do most disk surgery and treatment of traumatic lesions of the spinal column. The names of Dandy, Kraus, Stookey, Kham, Frickholm, Claward, Mayfield, Gardner, Scoville, Naffziger and Love are worthy of mention in connection with the above work.

Before Cushing, neurologic surgery was in the hands of general surgeons but Olivecrona's teachings and work on brain tumors, Sachs' advocation of better postoperative care of neurosurgical patients, Ingraham and Matson's teachings about neurologic surgery in infancy and childhood, Olivecrona, Makisak, Pool, and Hamby's writings on aneurysms, Poppen's organization of the steps of neurosurgical operations, Ray's idea of hypophysectomy for a variety of endocrine diseases, and Gardner's surgical treatment of syringomyelia and of the Arnold-Chiari malformation. DeMartel, from France, whose technical advancement of operating on the brain and spinal cord with the patient in a sitting position, and Gardner, who used the above philosophy in America, Walker and Scarff's stimulating writings on neurological surgery, Matson, Nielsen, Sayer, Pudenz, and Gardner's writings on hydrocephalus have made the handling of the patient much easier.

Little is known about the neurologic surgery behind the Iron Curtain, but still Professor Burdenko is well known as a pioneer in Russian neurologic surgery. His work, now being carried on by Professors Arutyunov, Palonov, and Yegorov, is important and no history, however brief, of neurologic surgery is complete without their names.

The future of neurologic surgery is limitless. In every phase there remain unanswered questions. Applications of atomic science, ultrasonics and radioactive elements in the localization and treatment of brain tumors offer promise for the future, but even in this Atomic Space Age unlocalized cerebral seizures and degenerative diseases of the cen-

are opiates now outmoded in pediatric diarrhea?



Entoquel™ syrup

(Thihexinol methylbromide)

the first pharmacologically-specific, non-narcotic antiperistaltic agent ■ controls diarrhea as rapidly and effectively as opiates ■ without the undesirable properties of opiates ■ pleasant butterscotch flavor

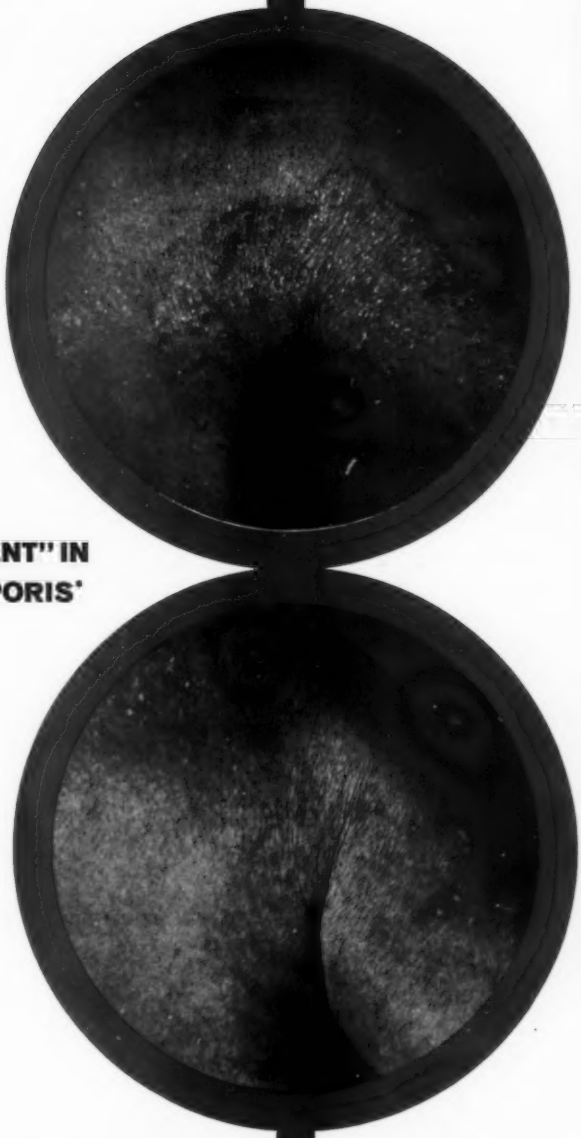
AND WHEN THE DIARRHEA IS BACTERIAL IN ORIGIN

Entoquel with Neomycin syrup

(Complete information regarding the use of Entoquel Syrup and Entoquel with Neomycin Syrup is available on request.)

Supplied: Entoquel Syrup – each 5 cc. contains 5 mg. thihexinol methylbromide, bottles of 6 oz. Entoquel with Neomycin Syrup – each 5 cc. contains 5 mg. thihexinol methylbromide and 50 mg. neomycin (from the sulfate), bottles of 6 oz. Available on Rx only.

WHITE LABORATORIES, INC., Kenilworth, New Jersey



Before GRIFULVIN, tinea corporis caused by *Trichophyton rubrum*. Demonstration of dermatophytic fungi by microscopic examination or culture differentiates this infection from non-ringworm disorders.

"RAPID CLINICAL IMPROVEMENT" IN TINEA CORPORIS[1]

After 30 days' treatment with GRIFULVIN.

tral nervous system are still an open challenge to the neurologic surgeon. The indisputable proof that neurologic surgery is becoming more and more effective and inviting increased interest all over the world lies in the fact that a rapidly growing number of young doctors are now entering this expanding field.

NEWS ROUNDS

Foreign MDs May Stay Beyond July 1st Deadline!

New York, N. Y.—Program Modified. Foreign medical graduates who failed the April ECFMG examination will be permitted to take the next examination given in this country, if hospital administrators act promptly to obtain permission from the U.S. State Department. This was stated here by Dr. John C. Nunemaker, associate secretary of the AMA Council on Medical Education and Hospitals, speaking at the convention of the Philippine Medical Association in America, on May 27. Hospital administrators can now request the State Department, via the district office of Immigration and Naturalization, that their foreign physicians be allowed to remain in the U.S. until the next examination is given and the results are known.

Take an "inside look" at a remarkable advance in topical steroid therapy

Veriderm Medrol consists of Veriderm, a base closely approximating the composition of normal skin lipids, and Medrol, highly effective corticoid.

Topical use of Veriderm Medrol Acetate produces symptomatic relief and objective improvement of dermatoses, and at the same time aids in correcting dry skin conditions. Veriderm Medrol Acetate, less greasy than an ointment, less drying than a lotion, is indicated in atopic, contact, or seborrheic dermatitis; neurodermatitis; anogenital pruritus; allergic dermatoses.

Available in four formulations: Veriderm Medrol Acetate 0.25% — Each gram contains: Medrol (methylprednisolone) Acetate 2.5 mg.; Methylparaben 4 mg.; Butyl-p-hydroxybenzoate 3 mg.; in a skin lipid base composed of saturated and unsaturated free fatty acids; triglycerol and other esters of fatty acids; saturated and unsaturated hydrocarbons; free cholesterol; high-molecular-weight alcohol; with water and aromatics. (Veriderm Medrol Acetate 1% is also available.)

For prophylaxis against secondary infection: Veriderm Neo-Medrol Acetate 0.25% — Each gram contains: Medrol (methylprednisolone) Acetate 2.5 mg.; Neomycin Sulfate 5 mg. (equivalent to 3.5 mg. neomycin base); Methylparaben 4 mg.; Butyl-p-hydroxybenzoate 3 mg.; in a skin lipid base composed of saturated and unsaturated free fatty acids; triglycerol and other esters of fatty acids; saturated and unsaturated hydrocarbons; free cholesterol; high-molecular-weight alcohol; with water and aromatics. (Veriderm Neo-Medrol Acetate 1% is also available.)

Administration: After careful cleansing of the affected skin to minimize the possibility of introducing infection, a small amount of either Veriderm Medrol Acetate or Neo-Medrol Acetate is applied and rubbed gently into the involved areas. Application should be made initially one to three times daily. Once control is achieved — usually within a few hours — the frequency of application should be reduced to the minimum necessary to avoid relapses. The 1% preparation is recommended for beginning treatment and the 0.25% preparation for maintenance therapy.

Contraindications: Local application of Veriderm Medrol Acetate or Neo-Medrol Acetate is contraindicated in tuberculosis of the skin and in other cutaneous infections for which an effective antibiotic or chemotherapeutic agent is not available for simultaneous application.

These preparations are usually well tolerated. However, if signs of irritation or sensitivity should develop, application should be discontinued. If bacterial infection should develop during the course of therapy, appropriate local or systemic antibiotic therapy should be instituted.

Supplied in 5 Gm. and 20 Gm. tubes.

Veriderm TRADEMARK

Medrol' ACETATE

Neo-Medrol' ACETATE

Upjohn

The Upjohn Company, Kalamazoo, Michigan

effective
therapy
in the
critical
pH
zone

Massengill® Powder

The buffered acid vaginal douche with low surface tens

The normal pH of the vagina (3-4.5) inhibits the growth of most pathogens, but menstruation and vaginal infections may cause the vaginal pH to rise . . . thus promoting greater growth of pathogens.

A simple acid douche will restore normal vaginal pH, but it is quickly neutralized by alkaline mucosa and pH rises again. Effective agents must be *buffered* to maintain the pH for several hours and be able to *penetrate* the folds of the vaginal mucosa for effective cleansing.

FORMULA: Ammonium Alum, Boric Acid, Phenol, Eucalyptol, Berberine, Menthol, Thymol and Methyl Salicylate.

A Massengill Powder douche provides effective therapy because it:

1 RESISTS NEUTRALIZING

The *buffered* acid douche solution of Massengill Powder (pH 3.5-4.5) resists neutralizing and this pH is maintained for 4 to 6 hours in ambulant patients . . . 24 hours in recumbent patients.

2 INHIBITS PROPAGATION OF PATHOGENS

Low pH of Massengill Powder solution inhibits propagation of monilia, trichomonas vaginalis and pathogenic bacteria while simultaneously promoting growth of beneficial Döderlein bacilli.

3 PENETRATES VAGINAL MUCOSAL FOLDS

Low surface tension of Massengill Powder solution is 50 dynes/cm. (vinegar is 72 dynes/cm.). This enables it to penetrate and cleanse folds of the vaginal mucosa. Low surface tension makes cell walls of infecting organisms more susceptible to therapy.

4 WON'T DEVELOP RESISTANT STRAINS

Because normal pH is restored, normal environment is created . . . pathogens can't thrive . . . resistant strains can't develop as with antibiotics.

5 IS ACCEPTABLE TO PATIENTS

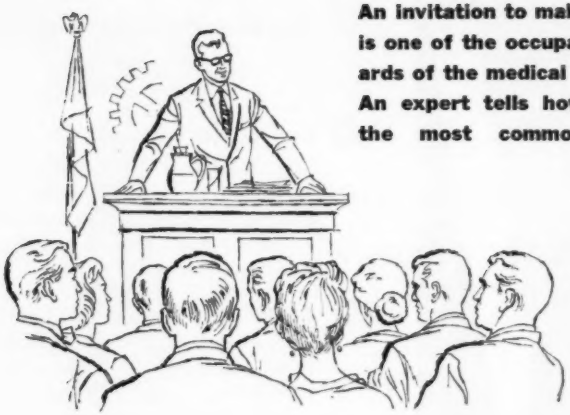
Clean, refreshing fragrance of Massengill Powder is acceptable to the most fastidious. Solutions are easily prepared, convenient to use, nonstaining . . . also soothing to inflamed mucosa.

Write for samples and literature

THE S. E. MASSENGILL COMPANY

BRISTOL, TENNESSEE

KANSAS CITY • NEW YORK • SAN FRANCISCO



An invitation to make a speech is one of the occupational hazards of the medical profession. An expert tells how to avoid the most common pitfalls.

Dave Hyatt, Ed.D.

So You Have to Make a Speech!

Whether you like it or not, as a practicing physician in the average community, you will frequently be called upon to deliver "a few well-chosen words" from a public platform.

And while no one really expects every doctor to be a silver-tongued orator, if you do accept a place at the lectern, you owe it to yourself and your associates to have taken the small trouble of mastering the fundamentals of effective public speaking. For whether your remarks are words of professional counsel or completely non-medical (as is often the case), you help determine a public image of yourself and your profession every time you speak. So why not speak well?

One of the main reasons why many addresses fail to capture an audience is simply because *the speaker has not sufficiently prepared himself.* That's basic.

for controlled therapeutic nutrition

during hospitalization and throughout convalescence

SUSTAGEN®

Complete therapeutic nutriment

to supply all or part of the patient's nutritional requirements

in the hospital...

When undernourishment complicates chronic disease or acute infection in hospitalized patients, Sustagen offers a therapeutic diet of carefully controlled, essential nutrients.[1] This diet helps to promote good nutrition and hasten convalescence.[1,2] In addition, because of the excellent gastrointestinal tolerance it affords, Sustagen is ideal for tube feeding.[1]

in the home...

The convalescent who continues to receive Sustagen at home is more likely to hold or increase his nutritional gains. Each glassful of the readily accepted beverage adds 390 calories to his diet, including 23.5 Gm. protein, 3.5 Gm. fat, and 66.5 Gm. carbohydrate —plus important quantities of all essential vitamins and minerals.

References: (1) Pareira, M. D., *et al.:* J.A.M.A *156*:810-816 (Oct. 30) 1954. (2) Winkelstein, A. Am. J. Gastroenterol. *27*:45-52 (Jan.) 1957.

Mead Johnson Laboratories

"It's about time someone developed a good analgesic that controls pain and also allows the patient to stay awake and cooperate better with the nursing staff."

"It's about time we had an analges that doesn't keep postoperative patients knocked out. I'd like to see them awake after operation. I'd worry less about hypostatic pneumonia and venous stasis."

Alvodine

ethanesulfon

Brand of piminodine ethanesulfonate

Alvodine is the first narcotic analgesic that provi practically "pure" analgesia. It relieves pain with causing drowsiness (93.7 per cent of 1577 patient or significant euphoria (99.2 per cent). When s follows the administration of Alvodine, it is due relief of pain, not to hypnosis. In therapeutic dos Alvodine is safer than morphine because it has li effect on respiration and circulation. Nausea and v iting are rare following its use. Unlike codeine

s about time a strong analgesic
ithout undue sedative action was
vailable for ambulatory patients.
Many of my cancer patients who are
p and around could use an agent
t doesn't make them drowsy,
oesn't force them to bed too soon."

"The time is here—
and the drug is Alvodine.
Alvodine relieves pain as well as morphine does, without causing hypnosis and with virtual absence of drowsiness. It should be the answer to your problems."

ew approach to "pure" analgesia

t provi hine, it does not cause constipation. Alvodine is
n with y effective when taken orally and may also be
patien by injection when necessary.
hen sl ***line tablets,*** 50 mg., scored. Average oral dose
is due ults: from 25 to 50 mg. every four to six hours
ic dosa quired. ***Alvodine ampuls,*** 1 cc. containing 20
has li er cc. Average subcutaneous or intramuscular
and v for adults: from 10 to 20 mg. every four hours
deine r quired. *Narcotic Blank Required.*

Winthrop LABORATORIES
New York 18, N. Y.

*Alvodine, trademark.

A study of the methods used by some of America's outstanding speakers shows they spend long hours of painstaking preparation for any speech.

Fulton J. Sheen, one of the most eloquent religious leaders of our time, has this to say regarding his method of preparing a lecture or sermon:

"Before writing a lecture, I spend a considerable time reading and thinking about the subject; in the case of a sermon the time is spent in meditation. I very seldom write out a lecture or sermon. Outlines are made however. Then I tear up the first outline and make another and repeat this process until the subject is well understood. In this manner, one is able to learn the talk from the inside out, rather than from the outside in. It is never memorized nor read; rather it is made a part of oneself through repeated contemplation of the subject. There's the story of an old Irish woman who heard a Bishop reading his sermon. Asked how she had liked the sermon, she said: 'Glory be to God, if he *can't remember it, how does he expect* us *to?'"*

Those who have heard Bishop Sheen speak will testify that he does seem to talk "from the inside out." That should be the goal of every speaker—to make what he says so much a part of himself that speaker and speech seem one and the same. This takes preparation.

By heart

The versatile and brilliant Mrs. Clare Boothe Luce, former congresswoman and past Ambassador to Italy, was asked her manner of developing a speech.

"The preparation I make for a speech depends (a) upon the size and knowledgeability of the audience; (b) whether or not the occasion will get press coverage and how much; (c) what other speakers will be likely to do, etc.

"During the 1944 political campaign I delivered over 100 speeches. About 12 of them were most carefully prepared, one-half or three-quarter-hour addresses. They were extensively documented. Each covered a national or international issue and was given advance press releases. The rest of the speeches were extemporaneous; some were delivered with notes; others were delivered without any. However, these latter speeches were all more or less reverberations or rewrites of the carefully prepared speeches to which I had added new facts and comments accord-

ing to the news events of the day.

"I always read from a prepared manuscript for a radio address—triple-spaced on the typewriter, 150 words (one minute) on the page, so I can always quickly cut as often becomes necessary when more than one person shares a radio program. When I deliver a speech over a public address system in a hall, although I have a manuscript—triple-spaced—before me, I seldom refer to it."

As in the case of Bishop Sheen, Mrs. Luce's speeches are uniquely her own, and speaker and speech seem inseparably one.

Time

When Bernard M. Baruch speaks, his words make headlines. America's elder statesman, commenting on his method of preparing a speech, says:

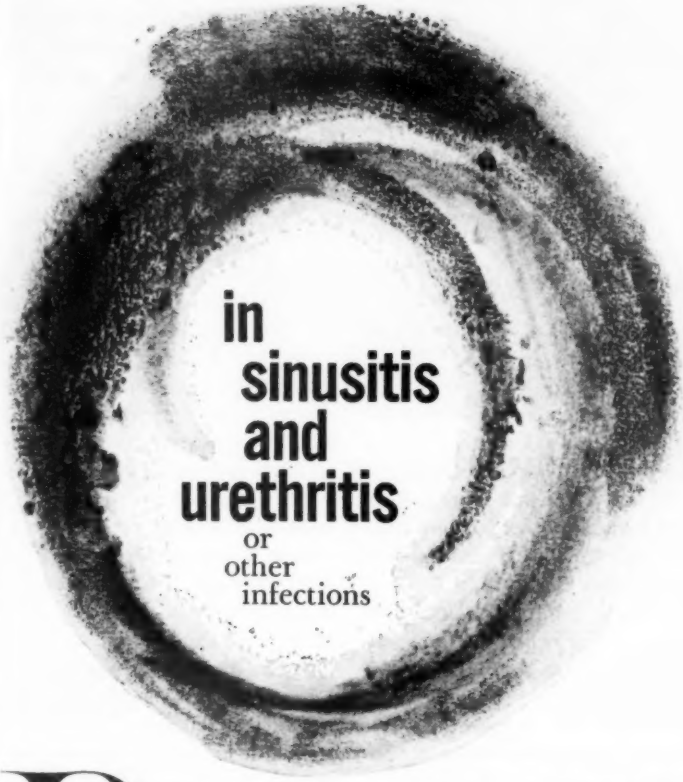
"I always read from a manuscript which is very carefully prepared. Sometimes I write it and sometimes I dictate it, but I give a great deal of time to every document."

Dr. Harry Emerson Fosdick, who for years held audiences spellbound from the pulpit of New York City's Riverside Church, explained his approach to public speaking in these words:

"I always write out any important speech with my own hand and then dictate it from notes to the dictaphone. After that I have several ways of preparation so far as delivery is concerned. I never memorize but I sometimes familiarize myself with my notes and speak extemporaneously, and sometimes I have before me a manuscript from which, however, I am careful to read as though I am not reading but speaking."

From the words of these speakers, all of them highly successful, it can easily be perceived

ABOUT THE AUTHOR In the fields of public relations, business and education, the author has had extensive experience as manager of public relations for the Hartford Accident and Indemnity Co., and with Merrill Lynch, Pierce, Fenner and Smith, investment brokerage house. Formerly on the faculty of Cornell University, he has authored numerous articles on speech and business and is presently vice president and director of public information for the National Conference of Christians and Jews.



antibiotic therapy with an added measure of protection

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

against relapse—up to 6 days' activity on 4 days' dosage
against secondary infection—sustained high activity levels
against "problem" pathogens—positive broad-spectrum antibiosis

CAPSULES, 150 mg., 75 mg.; PEDIATRIC DROPS, 60 mg./cc.; SYRUP, 75 mg./5 cc.
Request complete information on indications, dosage, precautions and contraindications from your Lederle representative or write to Medical Advisory Department.

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

that an effective speech may be prepared in any number of ways. But if there is any "rule" of public speaking, it is: *Prepare Your Speech.*

There are many formulas for developing the content of a speech. The important thing is that you keep the content alive and human. In organizing your material, this tried and proven format may be helpful:

- First, get the audience's attention—but whatever you say or do, make it pertinent to your subject.
- Link the subject to your listener's interests; make it important to them.
- Prove your point with interesting human illustrations.
- Ask your audience to do something about the subject upon which you have spoken.

Many of us are allergic to speeches because we have heard so many dull ones. So, you start with a handicap, but also with an opportunity. Your opening—an apt quotation, clever but pertinent anecdote, or amusing joke that relates to your subject—must give your audience hope that they are in for an imaginative and interesting speech. Danger: a bad joke, or one in poor taste, can chill your listeners, perhaps permanently. Better no anecdote than a poor one! Also, *be sure that the joke or story actually introduces your subject.*

As for the body of the talk, stay close to your three or four major points. Support them with human illustrations and case studies. As one effective speaker put it: "people are instinctively interested in other people."

One final point on content: it is psychologically effective to ask the audience to take some form of action. This doesn't necessarily mean the speaker must ask his listeners to do something as dynamic as signing a petition or writing a letter to Congress. He may simply ask his listeners to be more tolerant or to delve more deeply into the subject. A request for action, however, adds meaning and purpose to a speech —and a strong concluding note.

As for delivery, the most important thing to keep in mind is that people are fun to be with when they're completely themselves. This is as true on the

master craftsmanship

Master craftsmanship, traditional with RAMSES for almost a half century, stands behind the superb quality of every RAMSES Diaphragm—both the regular and the new BENDEX, an arc-ing spring diaphragm.

Quality and design make these RAMSES Diaphragms first choice of your women patients who appreciate elegance and comfort, along with known reliability.

Ramses® *Flexible Cushioned Diaphragm*

The regular RAMSES Diaphragm, suitable for most women, is constructed of pure gum rubber, with a dome that is unusually light and velvet smooth. The rim, encased in soft rubber, is flexible in all planes, permitting complete freedom of motion.

Ramses® BENDEX® *Flexible Cushioned Diaphragm*

For those women who prefer or require an arc-ing type diaphragm, the new RAMSES BENDEX embodies the superior features of the regular RAMSES *plus the very best hinge mechanism contained in any arc-ing diaphragm.*

RAMSES "TUK-A-WAY"® Kit #701—Designed like a fine accessory, this complete unit contains regular RAMSES Diaphragm 50 to 95 mm., with Introducer and 3 oz. tube RAMSES Vaginal Jelly. RAMSES "TUK-A-WAY" Kit #703—The same complete BENDEX unit minus Introducer (not required with arc-ing diaphragm). Sizes 65 to 90 mm.

Ramses "10-HOUR" Vaginal Jelly * *specifically for use with Ramses Diaphragms*

*Active agent, dodecaethyleneglycol monolaurate 5% in a base of long-lasting barrier effectiveness.

RAMSES, BENDEX and "TUK-A-WAY" are registered trade-marks of Julius Schmid, Inc.

JULIUS SCHMID, INC.
423 West 55th Street, New York 19, N. Y.

platform as anywhere else. One of the most engrossing things to witness on a stage is the magic of a skilled actor playing a role so truly there is nothing "actor-ish" about the part. The same is true of a speaker who is engrossed in his subject, enthused, and completely himself.

To put your audience at ease, you must put yourself at ease. An audience feels with a speaker. If you are comfortable, your listeners will enjoy and appreciate what you say. If you are embarrassed, they will be embarrassed for you.

Any sign of discomfort, any hint of lack of ease, any excess movement distracts the audience. The coat jerker, the pacer, the head scratcher, the collar puller, or the coin jingler detracts from the ideas he is trying to communicate. Do nothing that calls attention to yourself and which will inevitably draw attention away from what you are saying.

There are actions that will increase the straightforwardness of your speech:

1. LOOK AT YOUR AUDIENCE. Eye contact is of great assistance in communicating ideas. When talking to someone in ordinary conversation, you do not stare at the ceiling or at your shoes. Neither should you do so when speaking from the platform.

2. AVOID RANDOM MOVEMENT. People on the platform have a tendency to wiggle, to shuffle, to shift weight back and forth from one foot to the other, or to pace. Good speaking requires bodily action and energy. (Some people tend to speak from the neck up. This is inevitably ineffective.) But movements should be em ployed solely as an aid in making your speech more effective.

3. CONVERSE WITH THE AUDIENCE. Speaking is communication and communication is a two-way street. Use of "we," "you," and "all of us" aids in linking the speaker to his audience.

4. ORALLY UNDERLINE THE MAIN POINTS OF YOUR SPEECH. A speech can usually be made much more effective and clear to the audience if the main points are underlined by a distinct shift in volume and rate. Oral underlining can be done by slowing down, by dropping your voice, by speaking more loudly, or by speaking with greater emphasis.

5. WHEN REFERRING TO YOUR NOTES OR MANUSCRIPT, DO SO

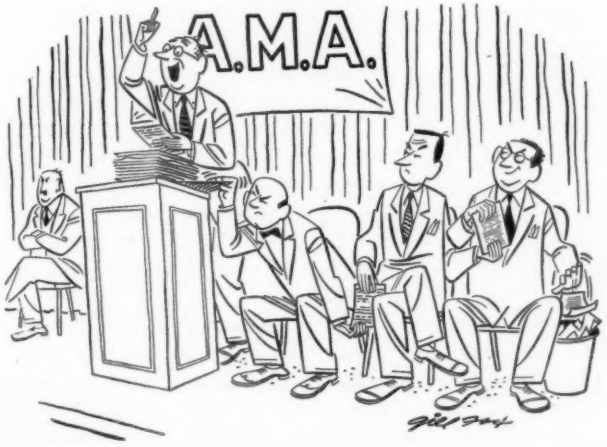
UNOBTRUSIVELY. There are many skilled speakers who can speak readily without use of notes. Yet, if you have trouble keeping on the main track, it's best to use notes or a manuscript. But don't bury your eyes in your notes; you will lose contact with your audience if you do.

6. ASK THE AUDIENCE QUESTIONS. Many successful speakers use the question as an attention-holding device. Even though they do not expect answers, they query their listeners. When one member of the audience is asked a question by the speaker, each member of the audience mentally responds.

If you are asked to read a professional paper, you need remember only four points:

- Practice read it once or twice.
- Speak out loud, let everyone hear. If there's a microphone, be certain you keep your proper distance.
- Speak clearly. Mumbling is an insult and an aggravation to your audience; if what you have to say is unimportant, don't read it.
- Keep your eyes on your audience as much as possible. To enable you to do this, have a clearly-typed, triple-spaced copy to read from.

Follow these simple suggestions and you will find that public speaking is easy. Not only that, it can be fun!



Your OVERSEAS Tour of Duty

As soon as you get that Army call, you'll be asked to state where you'd like to be stationed for your tour of duty. Your choice will be between the United States and overseas.

Alfred O. Heath, Capt., M.C., U.S.A.

An Army tour at an overseas station is challenging. Among other advantages, it offers you a chance to see a foreign country, travel, perhaps learn another language. Listed in the table are countries in which Army tours are available. The length of the tour depends on whether you have dependents or not.

After indicating your choice, you'll receive your orders in the mail. These will state where your permanent station will be. Formerly, medical officers did not learn of their permanent assignment until the third or fourth week at MFSS (medical field service school) at Fort Sam Houston, Texas.

As a Captain in the Medical Corps, your basic pay will depend on how much longevity (previous service, active duty or reserve) you have accrued. You will automatically get five years longevity for the time spent in medical school and internship, so

your minimum pay will run like this:

Basic Pay	$415.00
Incentive Pay	100.00
Quarters Allowance	102.60*
Subsistence	47.88
*$85.50 with no dependents.	$665.48

Overseas assignment

If you are destined for an assignment overseas, you will receive a welcoming letter from the Overseas Commander of your station. An officer will be assigned as your "sponsor" and as such he is responsible for getting you and your family settled in your new environment. If housing is available you will get concurrent travel (your family will travel with you), but if housing is not available you will get coordinated travel (your family will follow you when housing is available). It is well to start passport processing and immunization for your dependents early.

As soon as you get the address of your permanent station, make arrangements to have your household goods shipped. The government will pack and ship everything without cost to you. What you do not wish to ship will be stored at government expense until your service tour has been completed.

Housing is the chronic problem in the European area at the present time. No new quarters are being built for Army personnel and dependents. As soon as you arrive at your permanent station, the first thing to do is have your name placed on the housing list. This is done at the Billeting Office. In the meantime, you and your family may have to reside in the local town. Local housing is adequate, but usually differs greatly from American standards. However, you can utilize this time as an experience and an opportunity to learn about the culture and habits of the people in whose country you are staying.

Temporary housing is occasionally available on a sub-lease from other U.S. families. This is often on the top floor or in the basement of an apartment house. However, such accommodations run more to the form of an American apartment, offering central heating, bath and kitchen.

Housing waiting lists are divided according to the size of the apartment needed. The apartments run from two to four bedrooms in size.

Permanent quarters, constructed for Army personnel occupancy, are generally quite satisfactory. At one time, many of these were completely furnished with china and crystal as well as blankets and silver. But the

Doctor: The new respiratory stimulant described on the following four pages can be life-saving. It deserves your careful study and judicious use.

a new respiratory stimulant and "arousing

What is Emivan?

Emivan is the diethylamide of vanillic acid (3-methoxyl-4-hydroxybenzoic acid diethylamide).

Its principal action is central respiratory stimulation. Medullary center respiratory activity of the drug increases depth and to a lesser degree rate of breathing. "Arousing" effect at higher dosage has been ascribed to activity on the occipital lobes of the cerebral cortex.

Emivan is different in chemistry and in selectivity of action from other so-called "analeptic" drugs, such as nicotinic acid amides, tetrazols, amphetamines, or depressant-drug analogs.

When and how to use Emivan

Intravenous Emivan is used in patients with central nervous system depressant intoxication from barbiturates, sedatives, etc.; in severe respiratory and central depression caused by excessive CO_2 accumulation, as in pulmonary insufficiency; in "lightening" anesthesia and prevention of post-anesthesia respiratory complications.

Intravenous Emivan *does not replace,* but may be used to *supplement* the specific narcotic antagonists in the emergency treatment of narcotic intoxication.

Oral Emivan is used in the treatment or prevention of excessive CO_2 retention in patients with chronic respiratory insufficiency.

Emivan stimulates respiration with dramatic speed

Given intravenously, Emivan promptly—often within 60 seconds—stimulates respiration—even in severe CNS depression, and may awaken the less severely depressed patient.

Emivan is substantially safer, and more closely approaches the "ideal" respiratory stimulating agent

(a) Since Emivan acts selectively on the respiratory center of the medulla, rather than on all medullary control centers,[1,2] at therapeutic dosage it does not evoke certain undesirable side reactions of so-called "analeptic" agents.

Emivan apparently has no direct effect upon cardiovascular regulatory mechanisms. No changes in cardiac rate or rhythm have been observed following its use; nor has blood pressure been significantly affected.[3-5]

ingent EMIVAN®

BRAND OF ETHAMIVAN

response in seconds... singularly safe

- in CO_2 retention and central depression resulting from hypoventilation in pulmonary disorders, including obstructive pulmonary emphysema, cor pulmonale, etc.
- in life-threatening central nervous system depressant intoxication, as with barbiturates
- in "lightening" of general anesthesia; prevention of post-anesthetic respiratory complications

With Emivan, convulsion is rare, and has only followed large intravenous overdosage, is brief in duration, quickly self-reversing, and is not followed by secondary post-convulsive depression.[2,6]

(b) Emivan dosage is easily titrated to the response of the patient, and its action readily controlled by adjusting the dose; thus it may be used in continuous intravenous infusion.

Emivan provides a "life-saving airlift" – in drug-induced depression of the central nervous system

Many drugs, such as barbiturates, non-barbiturate sedatives and hypnotics, and some tranquilizers, when taken in accidental or suicidal overdosage, cause severe depression of the central nervous system, particularly the respiratory centers. Swift reversal of this CNS depression, with stimulation of spontaneous breathing, follows intravenous administration of Emivan. (See Product Brochure for details.)

Clinical results with Emivan in CNS depressant intoxication

Bernstine and Moskal:[4] In seven patients with severe barbiturate intoxication, Emivan administered intravenously aided in complete recovery within 12 hours or less, without the need for tracheotomy. All the patients showed a marked increase in depth and rate of breathing, without side effects. The rapidity and completeness of recovery in this group were in contrast to the convulsion caused with other stimulants prior to the availability of Emivan, as well as the prolonged recovery period requiring tracheal fenestration.

Leydic and Smith:[5] 26 deeply comatose patients intoxicated with CNS depressants (principally barbiturates) were treated with intravenous Emivan. The drug was given at 5 minute intervals in an average dose of 2 mg./kg. Emivan restored and maintained spontaneous respiration and protective reflexes in all but one; and accomplished rapid and complete awakening in 15. There were no clinical signs of drug toxicity, and significant side effects were not observed.

Similar life-saving results with intravenous Emivan in CNS depressant intoxication were also reported by Cole *et al.*, in JAMA[7]; Van Gasse[8]; Baum *et al*[9]; and Miller.[10]

(continued)

Emivan provides an "airlift" in respiratory depression associated with CO_2 accumulation resulting from hypoventilation

Emivan temporarily increases ventilation, and thus aids in the removal of excess carbon dioxide accumulating as a result of obstructive pulmonary defects. Boren[11] first pointed out that Emivan was an effective respiratory stimulant in the presence of severe respiratory acidosis. He demonstrated increased minute ventilation following 50 to 100 mg. of Emivan I.V. given over a period of one minute. Both volume and, to a lesser degree, rate of breathing were increased, despite the presence of markedly elevated blood-CO_2 levels and respiratory depression. These results were observed in patients with obstructive pulmonary defects, including pulmonary emphysema with bronchitis, cor pulmonale, and bronchogenic carcinoma.

In cases of severe CO_2 narcosis, intravenous Emivan overcame the apneic response to 100% oxygen breathing.[3] Boren found also, that in those patients who had responded to intravenous Emivan with improvement in ventilation and elimination of excess CO_2, *oral* Emivan, given in doses of 20 to 40 mg., usually q.i.d., effected gradual improvement during acute episodes of hypoventilation. Eventually this permitted withdrawal of the oral drug. All of these patients had severe pulmonary emphysema, and it was noted that in acute episodes of infection, "Emivan added to other forms of therapy was probably a big factor in allowing their survival...."[3]

Baum *et al.*[9] giving Emivan by intravenous infusion, recorded significant increases in minute ventilation (average 2.5 liters per minute) with corresponding reduction in arterial Pco_2 (average 4.1 mm. Hg.). Evidence was also obtained that respiratory-center sensitivity to CO_2 stimulus is increased during Emivan administration, and the improvement in tolerance to oxygen breathing in emphysema patients was confirmed.

Miller[10] found Emivan effective, by both intravenous and oral routes, as a stimulant to respiration in hypoventilation with CO_2 retention in chronic pulmonary disease and in obesity. An increase in the rate and depth of respiration was noted within 30 to 90 seconds after the intravenous administration of 50 to 100 mg. of Emivan. Fisherman[12] has also used oral Emivan, with improvement in respiration in 11 patients.

Emivan conveniently "lightens" anesthesia – shortens recovery room time – helps prevent post-anesthesia respiratory complications

Emivan is valuable – alone or as an adjunct to mechanically assisted breathing, in producing adequate ventilatory response, thus preventing post-anesthesia respiratory problems. When the anesthesiologist wishes to "lighten" general anesthesia, Emivan is prompt in awakening the anesthetized patient; restoring consciousness, voluntary responses, and easy spontaneous respiration; and improving general muscle tone.

Clinical results with Emivan in "lightening" anesthesia

Leydic and Smith:[5] Emivan was evaluated preliminarily as an anesthesia-"lightening" agent, following surgery in 350 cases. Duration of surgery ranged from 15 minutes to 8 hours, with an average of 2½ hours. "Definite arousal" was produced within 35 to 60 seconds in 74 percent of this series after a single slow intravenous injection of 2 mg./kg. of Emivan. The remainder responded after one or two additional injections at short intervals. There was an abrupt increase in minute volume of respiration, a return of corneal reflex, swallowing, motor response(rubbing of nose or mouth), and appropriate response to simple commands. Byers[13] administered 2 mg./kg. of Emivan intravenously to 72 cases

immediately after surgery, in which Surital alone, or with nitrous oxide or cyclopropane and Anectine®, had been the anesthetic agent. "The awakening or arousing effect was dramatic," reported this investigator.

Slater:[14] Oral surgery was performed on 58 ambulatory patients, ranging in age from 3 to 50 years, under various anesthetics. Emivan proved to be "an excellent respiratory and CNS stimulant with very little undesirable side effects.... Emivan has its greatest use in the recovery room by reducing significantly the length of stay for the patient," thereby economizing on staff duty time. Average time from general anesthesia to ambulatory state was 15 minutes.

Side effects

Depending upon the speed of intravenous injection, or the oral dosage used for a given level of central depression, certain transient side effects may at times be encountered. These may include: coughing, sneezing, laryngospasm, muscular twitching, itching, other pruritic manifestations, flushing and light-headedness. In many instances, these reactions, particularly the protective reflex stimuli to breathing, coughing and sneezing, have value as signposts to the progress of recovery of the patient.

Consult product brochure for administration, dosage, complete precautions and contraindications

Should coughing or sneezing endanger the immediate post-operative course of the anesthetized surgical patient (delicate ophthalmic surgery, repair of retinal detachment, etc.), Emivan should be used with great caution or not at all.

Supplied: 2 cc. ampuls containing 100 mg. of vanillic diethylamide and 10 cc. ampuls containing 500 mg. of vanillic diethylamide in 5% aqueous diethanolamine solution, for intravenous injection or infusion with intravenous fluids. 2 cc. ampuls, boxes of 5, 25, and 100; 10 cc. ampuls, boxes of 1, 5 and 25.

Tablets (uncoated) providing 20 mg. of vanillic diethylamide for oral use. Bottles of 100 and 500.

REFERENCES: 1. Ginzel, K. H.: Wien. Ztschr. inn. Med. *33*:16, 1952. 2. Buckley, J. P.: Personal Communications, March 21, 1960. 3. Boren, H. G.: Clinical use of vanillic diethylamide (Emivan) as a respiratory stimulant. In press. 4. Bernstine, M. L., and Moskal, J. P.: Anesthesiology *21*:90 (Jan.-Feb.) 1960. 5. Leydic, C. C., Jr., and Smith, H. D.: Clinical report on file at U.S. Vitamin & Pharmaceutical Corporation. 6. Miller, M. J.; Hand, B. M., and Crellin, J. A.: Preliminary report on the clinical use of vanillic diethylamide. Presented at Annual Meeting, American Therapeutic Society, Miami Beach, Florida (June) 1960. 7. Cole, G. W.; Marks, A., and Baum, G. L.: J.A.M.A. *174*:896 (Oct. 15) 1960. 8. Van Gasse, J. J.: Detailed reports on file at U.S. Vitamin & Pharmaceutical Corporation. 9. Baum, G. L.; Hagedorn, G.; Rosenstein, I. A., and Silipo, S.: Experiences with Emivan, a new respiratory stimulant. Presented at 17th Annual Meeting, American College of Chest Physicians, St. Louis, Mo., October 1960. 10. Miller, W. F.: (a) Clinical Report on file at U.S. Vitamin & Pharmaceutical Corporation. (b) Scientific exhibit presented at A.M.A. Annual Meeting, Miami Beach, Florida, June 13-17, 1960. 11. Boren, H. G.: M. Clin. North America, *43*:33 (Jan.) 1959. 12. Fisherman, E. W.: Personal Communication, Jan. 22, 1960. 13. Byers, R. J.: Personal Communication, January 26, 1960. 14. Slater, H. M.: Vanillic diethylamide (Emivan) for post-anesthetic recovery, report presented at 16th Annual Meeting Western Division Canadian Anesthetic Society, Winnipeg, Manitoba, March 9, 1961.

a new respiratory stimulant and "arousing" agent . . .
response in seconds, singularly safe

EMIVAN

U.S. VITAMIN & PHARMACEUTICAL CORPORATION

Arlington-Funk Laboratories, division
800 Second Ave., New York 17, N. Y.

LENGTH OF OVERSEAS TOUR

	WITH DEPENDENTS	WITHOUT DEPENDENTS
ALASKA	36 months	24 months
AZORES	24 "	18 "
ENGLAND	36 "	24 "
ETHIOPIA	24 "	24 "
FRANCE	36 "	24 "
GERMANY	36 "	24 "
GREECE	30 "	30 "
GREENLAND	24 "	12 "
GUAM	24 "	18 "
HAWAII	36 "	24 "
ICELAND	24 "	12 "
IRAN	24 "	18 "
IRAQ	24 "	24 "
ITALY	36 "	24 "
JAPAN	36 "	24 "
KOREA	* "	18 "
OKINAWA	36 "	24 "
PAKISTAN	24 "	18 "
PANAMA	36 "	24 "
PUERTO RICO	36 "	24 "
TAIWAN	24 "	15 "
THAILAND	24 "	13 "
TURKEY	24 "	24 "
VIET NAM	24 "	12 "

* Dependent travel not allowed.

policy of providing such accessories no longer exists, and it is probable that you will have to supply your own. Most families bring their own accessories with them, which tends to make the apartments more individual. All apartments are completely furnished with bedroom furniture, living and dining room furniture as well as bookcases. However, if you are assigned to France or Italy you will need complete household furnishings. The apartments are usually painted every three or four years. Your "sponsor" will advise you on specific housing conditions existing in your duty area. Time off so you can get your family settled is

The 613-R Dynaclave
Low-cost, high-speed autoclave — portable automatic — efficient

The 1022 Aristocrat Autoclave
Office pressure steam sterilization to hospital standards and convenience

EVERY PHYSICIAN

CAN NOW GIVE PATIENTS THE POSITIVE PROTECTION OF PRESSURE STEAM STERILIZATION

The NEW 8816M Autoclave
Redesigned to meet the same exacting sterilization standards of the 8816, but at substantially lower cost and with greater capacity.

One of these Amsco Autoclaves can substantially aid your efforts toward improved patient protection against the contaminated needle, or other instruments in your office.

Assurance of the positive protection of pressure steam sterilization is a comfort appreciated most highly by the physician who has faced the problem of cross-contamination. There is an authorized Amsco Dealer near you — ready to advise and serve your requirements for sterilization equipment and adequate techniques. Mailing this coupon with your letterhead will bring full details . . .

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

Service Centers in . . .
Atlanta, Boston, Chicago, Cincinnati, Dallas, Denver, Detroit, Los Angeles, New Orleans, New York City, Philadelphia, Pittsburgh, Richmond, St. Louis, St. Paul, San Francisco, Seattle, Tampa, Washington, D. C., including a dispersed Amsco Serviceman

Send Bulletin on Autoclaves 613-R ☐ 8816M ☐ 102
and location of nearest Amsco Dealer

Name

Address

City Zone State

granted as a routine policy.

Your car is also shipped at Government expense. It should be in safe operating condition. Be sure to have a complete set of keys to turn in with the vehicle at the time of delivery to the port of embarkation. Protect the motor with sufficient antifreeze, where necessary, and do not leave anything other than essential tools and spare parts in the vehicle. Unlock all compartments and don't leave firearms, ammunition or inflammables in the vehicle. It is essential that you do not deliver your auto to the port with more than a minimum of gasoline in the tank.

When your car arrives at its overseas destination, you will receive word from the port of entry. You will be granted administrative leave to pick it up. Army post exchange garages are available in Europe and can provide almost any type of repair or service needed.

Upon arriving in Europe, you will find that the ration system is in effect. This is not due to the scarcity of commodities. In some countries certain items (gasoline, coffee, cigarettes and liquor, for example) are limited because an excess amount, with improper handling, could create a problem in illicit, black market-type dealings. You are allotted more than enough coupons to satisfy your own personal needs.

There are several social functions, formal and informal. At some posts the dress blue uniform is mandatory. Before you purchase one, find out the policy at the post to which you are assigned. Civilian clothes are usually worn after duty hours.

Throughout the year you accumulate 30 days leave time. You can also get a 72-hour pass from time to time, not chargeable to your leave periods. Special Services arranges trips; they are reasonable and worth the money.

The success of your Army tour depends almost completely on your attitude. As in most situations, you will get out of it what you put into it. There will be problems, of course. But nothing you won't be able to handle if you're attitude is matured and constructive. Above all, don't be critical of the Army or the customs, habits or people of the land in which you are serving your tour, regardless of the temptation or provocation.

Look forward to the best and I am sure you will find, as I did, that your overseas tour will be a rich and rewarding one.

Mellaril®

THIORIDAZINE HCl

provides highly effective tranquilization, relieves agitation, apprehension, anxiety

and "screens out" certain side effects of tranquilizers, making it virtually free of:

In Agitated Medical/Surgical Patients – "A new phenothiazine derivative, thioridazine [Mellaril], was used to treat 71 patients, most of whom were unduly agitated and disturbed due to hospitalization for medical or surgical conditions. . . . The response to treatment was considered satisfactory in 83.4 per cent of patients. . . . In agreement with the published results of other investigators, we believe that thioridazine shows a greater specificity of tranquilizing action and freedom from serious toxic effects when compared with some of the other phenothiazines."[1]

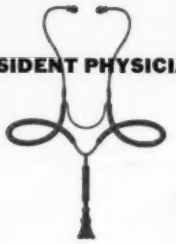
Mellaril is indicated for varying degrees of agitation, apprehension, and anxiety in both ambulatory and hospitalized patients.

Usual starting dose: Non-psychotic patients – 10 or 25 mg., t.i.d. Psychotic patients – 100 mg. t.i.d. Dosage must be individually adjusted until optimal response. Maximum recommended dosage: 800 mg. daily. Supply: Mellaril Tablets, 10 mg., 25 mg., 50 mg., 100 mg.

1. David, N. A.; Logan, N. D., and Porter, G. A.: Evaluation of Thioridazine (Mellaril), a New Phenothiazine, in The Hospitalized Patient, A.M. & C.T. 7:364 (June) 1960.

ORIGINAL RESEARCH SERVING THE PHYSICIAN

SANDOZ



Ohio Conference on Intern

Nearly 100 medical students had an unusual opportunity to ask questions and hear the often sharply divergent views of a panel of leading medical educators in the special meeting on internship held May 20, at Riverside Methodist Hospital, Columbus, Ohio. Questions directed to the panel during the latter half of the four-hour conference revealed the real concern of the students in making a choice of type of internship, and the relative lack of information on which to base their decision. However, the candid approach to the subject by the panelists brought out a number of factors that the medical student could consider in appraising his first step into graduate medical education. Our RESIDENT PHYSICIAN editor who attended the meeting prepared the excerpts on these pages from a transcript of the proceedings.

nternship

Dr. Francis P. Kintz, Director of Medical Education at the host hospital, opened the conference by stating: "The purpose of the meeting is primarily to get across to you some information relative to the internship, why we have an internship, what you should look for in an internship and what you should expect to get out of an internship . . . "

Dr. Herrick, panel moderator, asked each panelist to identify himself as to the type of training he had had as well as to what his present position was. "I think it is impossible to give information about something as controversial as type of internships without injecting a little bit of bias. I think perhaps you will hear more than a little bit of bias here this afternoon. We would like to give you a body of knowledge to work with so that when you come to choosing your internship, and talking with your associate dean about your internship, you may be in a better position to judge whether this type of internship is best for your future plans or not."

PANEL MEMBERS

CHAIRMAN

FRANCIS P. KINTZ, M.D., Director of Medical Education, Riverside Methodist-White Cross Hospitals.

MODERATOR

PHILIP D. HERRICK, M.D., Director of Medical Education, Beverly Hospital, Beverly, Massachusetts.

PANEL

JOHN CAUGHEY, M.D., Assistant Dean, Western Reserve University Medical School.

LAWRENCE FISHER, PH.D., Department of Research in Medical Education, University of Illinois College of Medicine.

C. E. KIELY, JR., M.D., Assistant Dean, University of Cincinnati Medical School.

WILLIAM J. LAHEY, M.D., St. Francis Hospital, Hartford, Connecticut.

CHARLES LEEDHAM, M.D., Director Medical Education, Frank E. Bunts Educational Institute and Cleveland Clinics, Cleveland, Ohio.

ROGER WILLIAMS, M.D., Assistant Director, Department of Surgery, Ohio State University College of Medicine.

COL. HAYDEN W. WITHERS, M.D., USAF (MC), Assistant for Personnel (Health and Medical), Office of the Assistant Secretary of Defense.

The panel reflected a diverse background in medicine and surgery. Both university and non-university hospitals were represented as well as voluntary, private and government institutions.

Purpose

DR. FISHER: "I know that personal worth and individual responsibility have been beaten down to absolute zero as you go through medical school, but now you are suddenly called upon to fertilize it, water it, and get it growing again as you come into the internship. Representing a private hospital, I feel that a private hospital perhaps can give greater scope for this."

DR. KIELY: "It seems to me the purpose of an internship is to enable a student to translate his diagnostic knowledge into practical bedside care . . . I would submit that no matter what kind of an internship, whether rotating, family or straight, this is what happens during this year . . ."

DR. LAHEY: "I feel that the student should make sure that the primary emphasis in the internship is placed on the rigorous discipline of medicine . . . There is an increasing body of knowledge that indicates that the thing that sets apart the physician who maintains superior performance in the latter years of his practice is his adherence to the discipline of thorough diagnostic approach, the history and physical examination done with quality. This is the individual who maintains his stature as against the individual who may become a mere technician."

DR. CAUGHEY: "One of the simplest decisions that I know of is if you decide you want to stay in the university—you want to do teaching and research—then you'd better stay in the university. This seems relatively simple to me. I believe that the decision that a student makes about internship is simply one step further on his educational road—and it is a great mistake to think of it as an irrevocable step, or a step which is so vital that if you make the wrong move you are going to ruin your whole future."

Investment

". . . I think the principle of investment applies here just as it does in so many other medical situations. If you want to get something out of an internship, you have to put something into it, and I don't know really of any internship in the country where, if you go to it with enthusiasm and effort and put a lot in, you won't get a lot out of it . . . I don't believe there is any perfect internship. In fact, I don't think there is any best internship. This is one of the terms that should be abandoned. There is no one internship

The conference was supported by a grant from the Merck Sharp & Dohme Post graduate program.

that is best for everybody. There are some people who should turn down a much sought after internship, such as Medicine at the Massachusetts General Hospital, because it just does not fit with their particular aptitudes, interests and objectives."

DR. LEEDHAM: "... The best way to find out about an internship is talk to an intern who has just completed or is in the middle of an internship or a resident who has just completed his internship. People like myself are very prejudiced and you may get the idea we have the best internship in the world. So will Dr. Caughey, or any other member here; but if you really want to know what makes the place go, ask an intern or resident . . . ask two; talk to them."

Hospital

DR. LAHEY: "... the major pressures are still those of—in too many hospitals—of getting assistants to help the practicing physician in his practice. That is why I think, as Dr. Caughey said earlier, that we have got to get away from talking about the best internship or arbitrarily lumping all straight university internships into one shining category and all rotating internships into another category, with variable shininess. We have to focus on what is going on in the individual hospital . . . My point is . . . I think you have to consider a hospital and its program individually. You find superior programs in the nonuniversity area; you obviously find superior programs within the university area."

DR. WILLIAMS: "I don't feel a rotating internship should be taken with the idea that that is when you are going to make up your mind what you are going to do, because then, in my experience, most people still have to take about two years in service to make up their mind. Many of you won't make up your minds until you have been in practice five years. I am willing to take a bet that of all of those planning on going into general practice, roughly one-half will be back for training in some specialty within the next ten years."

Staff problems

DR. CAUGHEY: "The actual fact of the matter is that the rotating internship today, especially in the big teaching hospitals, is becoming a very, very difficult problem for the staff. The reason is that we are upgrading medical students so much by giving them increased responsibility in their fourth year, that they are squeezing the rotating intern from below. We have seen the residency programs proliferate to such an extent that they are really becoming the major interests of the departments in the training of graduate physicians. This puts the rotating intern in between the faculty's pressure to

upgrade the senior students—and the department's primary interest in its own residents; and this is going to get worse before it gets any better as far as I am concerned."

DR. FISHER: "You have to do some self-diagnosis. I think the best indicating factors of how a young man is doing in his internship is for one of the attending men to ask him near the end, 'What do you do well? Now, what do you do poorly?' I find that a poor intern can't answer either of these questions; a good intern can answer them extremely lucidly."

NEWS ROUNDS

Society Approves Fees to Residents

Insured Patients to be Source—Education costs and the shortage of clinical material for teaching purposes were cited as reasons for a resolution passed by the New York County Medical Society, at its May meeting, approving insurance fee payments to residents. Recognizing that some hospitals were currently collecting fee payments from insured patients treated by residents, the Society's resolution stated in part: " . . . only the professional staff rendering these services should benefit from such fees . . . " The resolution calls for patients not having a personal physician to select either 1) a personal physician from the attending staff or 2) admission to the teaching service under the immediate care of residents in accredited training programs. Fees for the latter group would go into a special fund "under the sole control" of the hospital's medical board and "applied only to costs ascribable to . . . (accredited) . . . training programs." The resolution will be voted on again in November.

QUIET, PLEASE!

YOUR WIFE'S TALKING

HOUSE PARTY:
High Style on a House Staff Stipend

Marjorie Deutsch

There's a word for it!

When you're a house staffer's wife — be he intern or resident—one word comes to mind when hubby thoughtfully reminds you that "we must have so-and-so over for the evening; it's been such a long time; they've had us over *twice* since Christmas . . ."

The word is, of course, BUDGET. (In our house we always spell it with capitals.)

We all know entertaining can be costly. As medical wives we also know that our weekly grocery allotment barely covers the cost of scrambled eggs or hamburgers for ourselves when our husbands are on duty, meat loaf for two, when he's home, and junior foods for junior.

Company coming makes you think of exotic stuff like chicken paprika, shish kebab, sweet 'n' sour spareribs and strawberry cheese pie—but that word, BUDGET, is apt to give you pause. So you juggle the dollars and come up with grilled hot dogs and cherry pop, the onion soup, cheese dip, some pretzels and potato chips, perhaps a frozen apple pie.

It's what you served last time, probably; but after all, your husband's *not* in practice and you had to leave your very

nice job a year ago because of the baby and . . .

Attractive array

But gals, did you ever stop to think that you can produce as bountiful a table as the wife of—say — the chief of surgery at hubby's hospital? As attractive an array of foods and drink as those pictured—in color—in the slick magazines? Well, you can. And besides, the cost won't floor you. You won't even go over the BUDGET. And you'll forget that you ever had to rely on the trusty frankfurter.

Let's start with the before-dinner cocktail. Mixed cocktails are nice, but only if you've a well-stocked liquor cabinet with a wallet to match. My resident-husband and I have found that most everyone likes vodka, a most reasonably priced beverage; and so we concoct a jug of Screwdrivers or Bloody Marys — or both; have on hand an aperitif wine, such as Thunderbird, as well as an aftermeal cordial. For the soft-drinking guests, why not a pitcher of lemonade (the frozen is fine) or fruit punch rather than bottled carbonated drinks? The pennies go much further that way.

Nibblers and snacks can hike up your food bills, mainly because a 29c bag of potato chips can't be stretched beyond three hungry guests. Make your own nibbles from commercial wheat or oat cereals; specifically, those in alphabet shapes (but not the sugared). Just melt some margarine or salad oil in a saucepan, add garlic powder, salt, paprika or any combination of spices, throw in a generous amount of cereal (a large box is only 29¢), heat until crisp and browned, drain on paper-toweling and presto — you've got several bowlsful of a taste-tempting tidbit.

Puffs

There's no need to impress your company with caviar or pâté on crackers. Mayonnaise puffs will look just as pretty and taste superb.

HOT MAYONNAISE PUFFS

1 cup real mayonnaise
1 egg white, stiffly beaten
Crackers or toast rounds

Fold mayonnaise into egg white until well-blended. Place dollop of mixture on crackers; top with minced onion or paprika, if desired. Place under broiler, toast for about one minute or until delicately browned and puffed. Serve immediately.

in emergencies

INJECTION

Hydrocortone® PHOSPHATE

HYDROCORTISONE 21-PHOSPHATE

in the patient in 30 seconds · in the plasma in 5 minutes

1. No dilution 2. No mixing 3. No waiting . . . in stable solution ready-to-inject with small-bore needle. . . . Plasma steroid levels are evident within 5 minutes after injection by any route . . . intravenous, intramuscular or subcutaneous.

After intramuscular injection . . .
higher initial steroid plasma levels than with hydrocortisone hemisuccinate.

After intramuscular or intravenous injection . . .
more prolonged steroid levels than with hydrocortisone hemisuccinate.

DOSAGE: The usual dose of Injection HYDROCORTONE Phosphate in emergency situations is 100 to 250 mg. depending upon the severity of the condition. For additional information see package circular.

SUPPLIED: In 2-cc. vials, each cc. containing 50 mg. HYDROCORTONE (as hydrocortisone 21-phosphate, disodium salt). Also available—Injection HYDELTRASOL® (prednisolone 21-phosphate) in 2-cc. and 5-cc. vials, each cc. containing 20 mg. of prednisolone 21-phosphate as the disodium salt. Injection DECADRON® Phosphate in 5-cc. vials, each cc. containing 4 mg. dexamethasone 21-phosphate as the disodium salt.

Hydrocortone, Hydeltrasol and Decadron are trademarks of Merck & Co., INC.

Additional information is available to physicians on request.

MSD MERCK SHARP & DOHME, Division of Merck & Co., INC., West Point, Pa.

Dips

When you watch your figure (and who isn't?) as well as the BUDGET, you know how the calories mount up for rich cheese dips scooped up with potato and corn chips. A lo-cal centerpiece that I often use is as attractive as it is healthy—and non-thickening for the waistline.

The dip portion, surrounded by various fresh vegetables, is Russian dressing; if used sparingly, it won't wreak havoc with anyone's diet. Half mayonnaise-half catsup or chili sauce plus a dab of lemon juice, all mixed well, centers the platter of carrot strips, celery stalks, cucumber fingers, raw flowerets of cauliflower, green pepper rings and raw pea pods. If dinner is on the schedule for the evening's menu, this hors d'oeuvre may very well eliminate the fuss of a salad with the main course.

When we're not serving a buffet dinner, I like to have one or two hot dishes to accompany the drinks. That old standby—hamburger — that nourished us through medical school and internship still does the trick in residency—although it has taken on a more exotic aura. Vi's Meatballs, served over hot rice will take the raves at your next party. (And no one will realize that it's the same recipe you can use for tomorrow's meat loaf!)

VI'S MEATBALLS

1½ lbs. ground beef
3 slices bread, crumbled
Approx. ¾ cup ice water
Can commercial tomato soup;
1 onion, sliced in thin rings
2 eggs
Salt, pepper, minced onion, other spices, all to taste

In bowl place bread crumbs with enough ice water to cover. Add meat, spices. Mix until of spongy consistency. Add eggs. Blend until mixture appears shiny. Meanwhile, place soup, diluted with one soup-can of water, in a large saucepan, add onion rings and bring to a boil. Form little meat balls with a tablespoon, drop into saucepan, cover and simmer. Cook about an hour. Heat in original pot before transferring to a chafing dish at serving time.

(For tomorrow's meat loaf, eliminate the soup step, but place the meat mixture in a baking pan for baking at 375° for 1½ hours.)

ABOUT THE AUTHOR

Wife of a surgical resident at an upstate New York medical center, the author has a B.S. in journalism, and worked for a literary agency before becoming an editor for Kodakery, a publication for Eastman Kodak employees in Rochester, New York. She has two hobbies, writing and cooking.

Wine and wiggle

Another excellent chafing dish recipe is Shrimp Wiggle; but don't let "white wine" on the list of ingredients frighten you. Average price for a bottle is 89-99¢.

SHRIMP WIGGLE

3 tablespoons margarine
2 tablespoons flour
½ cup milk
½ cup white wine (Sauterne, Chablis, etc.)
1 pkg. frozen peas
1 lb. cleaned, peeled, boiled shrimp
1 egg yolk
1 teaspoon lemon juice
½ cup sliced ripe black olives
2 tablespoons toasted almonds or water chestnuts (optional)
Bread crumbs

Make cream sauce by melting margarine, blending flour and adding liquid. Remove from fire after sauce thickens, stir in unbeaten egg yolk. Add remaining ingredients, place in buttered casserole or chafing dish, cover with bread crumbs and small dots of margarine or butter. Bake in 350° oven for 30 minutes. Before serving, re-heat in oven, then keep warm in chafing dish.

Hospital food being what it is, most medical men like something a bit exotic in food during off-hours. Ever experiment with Chinese cooking, for example? We like the American version of Mandarin spareribs, which are economical as well as tasty. Substitute lamb riblets for pork spareribs; the former are lower in cost and, when properly treated, taste precisely like the ribs you've been munching in your favorite chow mein hangout. Like pork, lamb riblets come either in racks or singly; whichever you prefer suits this recipe.

Broil the ribs (indoors or over charcoal) until well-done on both sides. Salt and pepper may be added after turning. When cooking outdoors, merely baste the meat with barbecue sauce to complete. Indoors, finish the process in the oven by covering broiled ribs with sauce and placing in 325° oven for 45 minutes.

For the sauce: mix commercial spareribs marinade (sometimes called duck or plum sauce) with an equal amount of catsup, plus a dash of lemon juice, soy sauce, perhaps a soupcon of Tobasco — all to taste — and you've got a simple, "made-it-myself" baster. If you wish, ribs may be broiled earlier in the day and barbecued in the oven later that evening when the guests arrive.

Another company dish in the Chinese manner is Pepper Steak, prepared either from round or chuck steak or leftover beef.

Pepper Steaks

1½ lbs. beef in strips
1 green pepper
1 onion, sliced into rings
1 or 2 small cans mushrooms
#2 can stewed tomatoes
1 cup fresh celery, cubed
Salt, pepper, soy sauce to taste

Cover frying pan with salad oil. Add beef, cook until browned over high flame. Add cut-up strips of green pepper and onion, keeping flame high. Add seasonings; taste and test for over-saltiness. (Go lightly on soy sauce.) Add mushrooms, celery, stewed tomatoes. Cover skillet, lower flame to simmer, and cook until meat is tender — approximately 1 hour. Serve over hot rice and garnish with crisp fried noodles.

Shish kebab

Shish Kebab is delicious when tenderloin or sirloin steaks are used, but your results can be mouth-watering with a budgeteer's dream—the bottom round steak. Merely "doctor" the meat with commercial tenderizer (directions on package) cut into 1 inch chunks and marinate overnight in a mixture of salad oil, vinegar, garlic salt and soy sauce. Use equal amounts of vinegar and soy sauce; double that, and you know how much oil to use. Before preparing, thread the meat on skewers with pineapple chunks, mushroom caps, small canned potatoes, tomato quarters, green pepper pieces — or whatever combinations you can dream up. Broil in your oven or rotisseries or over an outdoor fire. Turn occasionally and baste with leftover marinade. Simply wonderful—and your guests will wonder what heavenly ingredients went into their meals-on-a-stick.

Barbecue chicken

If a full dinner is included in your menu, then chicken is just the dish for you. Not only is it economical, but it can also be mighty glamorous when prepared the right way. But first, here's a recipe for the group that doesn't mind smudged fingers to demolish a platter of barbecued chicken. Indoors or out, the recipe is the same. Mix about ½ cup salad oil with ¼ cup lemon juice, salt, paprika, and stir well. This is the baster used while chicken is being broiled. Keep turning fowl and baste constantly. When chicken is done (after approximately 40 minutes) baste with same sauce used for lambs riblets. You can't miss with this recipe!

In the more formal vein, Chicken Paprika is delicious both for you and your pocketbook. Here's my own recipe patterned after the Hungarian version.

Can a plumber do a day's work on 1200 calories?

The answer, of course, is "not for long." For example, following diagnosis of diabetes, a 44-year-old plumber (5'8" and weighing 147 lb.) had been put on a 1200-calorie diet to control glycosuria. When referred six months later, he had not been spilling sugar, but had lost 25 pounds and developed progressive fatigability. Orinase, 0.5 Gm./day, was prescribed and his diet was increased to 2800 calories to meet metabolic demands (125 Gm. protein; 300 Gm. carbohydrate; 125 Gm. fat).

Follow-up visits showed this progress:

3 mo. Urine and blood sugar o.k.; weight gain: 28 lb. Can work normally, feels generally well.

6 mo. Weight constant, control constant, no complaints.

12 mo. Same.

18 mo. Same.

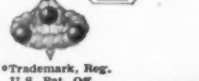
24 mo. Same.

Diet-controlled diabetics who are underweight, tire easily, or have increased nutritional needs may merely be "getting by" on dietotherapy alone. These patients—and others who experience transient weakness or listlessness—can often be returned to near-normal activity by giving Orinase together with a more adequate diet. Orinase control of diabetes is notably smooth and stable; patients report a greater sense of well-being, and improved mood.

Case data courtesy Henry Dolger, M.D.

Orinase*

An exclusive methyl "governor" prevents hypoglycemia.



*Trademark, Reg. U.S. Pat. Off. tolbutamide, Upjohn

The Upjohn Company
Kalamazoo, Michigan

Upjohn

Indications and effects: The clinical indication for Orinase is stable diabetes mellitus. Its use brings about the lowering of blood sugar; glycosuria diminishes, and such symptoms as pruritus, polyuria, and polyphagia disappear.

Dosage: There is no fixed regimen for initiating Orinase therapy. A simple and effective method is as follows: *First day*—6 tablets; *second day*—4 tablets; *third day*—2 tablets. The daily dose is then adjusted — raised, lowered or maintained at the two-tablet level, whichever is necessary to maintain optimum control.

In patients being converted from insulin, insulin is gradually withdrawn in accordance with the response to Orinase observed over a trial period that may extend to three or four weeks. In candidates for combined Orinase-insulin therapy, an individualized schedule is usually obtainable during a trial course of two or more weeks.

Contraindications and side effects: Orinase is contraindicated in patients having juvenile or growth-onset, unstable or brittle types of diabetes mellitus; history of diabetic coma, fever, severe trauma or gangrene.

Side effects are mild, transient and limited to approximately 3% of patients. Hypoglycemia and toxic reactions are extremely rare. Hypoglycemia is most likely to occur during the period of transition from insulin to Orinase. Other untoward reactions to Orinase are usually not of a serious nature and consist principally of gastrointestinal disturbances, headache, and variable allergic skin manifestations. The gastrointestinal disturbances (nausea, epigastric fullness, heartburn) and headache appear to be related to the size of the dose, and they frequently disappear when dosage is reduced to maintenance levels or the total daily dose is administered in divided portions after meals. The allergic skin manifestations (pruritus, erythema and urticarial, morbilliform, or maculopapular eruptions) are transient reactions, which frequently disappear with continued drug administration. However, if the skin reactions persist, Orinase should be discontinued.

Clinical toxicity: Orinase appears to be remarkably free from gross clinical toxicity on the basis of experience accumulated during more than four years of clinical use. Crystalluria or other untoward effects on renal function have not been observed. Long-term studies of hepatic function in humans and experience in over 600,000 diabetics have shown Orinase to be remarkably free of hepatic toxicity. There has been reported only one case of cholestatic jaundice related to Orinase administration, which occurred in a patient with pre-existing liver disease and which rapidly reversed upon discontinuance of the drug.

Each tablet contains: Tolbutamide .... 0.5 Gm.

Supplied: In bottles of 50.

Chicken Paprika

2 broiler-fryers, cut up
¼ cup salad oil (may be part olive oil)
1 cup commercial sour cream
1 cup white wine (using our bargain bottle once again!)
Bread crumbs—enough to coat chicken
Oregano, thyme, salt, pepper, paprika
#2 can stewed tomatoes
Small can mushrooms

Roll cleansed, rinsed chicken parts into mixture of crumbs and spices. Heat oil in heavy skillet until sizzling, then brown chicken well on both sides. Add ½ cup wine, a dash of water and let simmer in covered skillet until fork-tender. When poultry has become tender, add ½ cup sour cream, can tomatoes and mushrooms. When heated throughout, remove chicken from skillet and arrange in oven pan—juices and all. Pour remaining sour cream over fowl, and bake for approximately 15 minutes in a 250° oven. Serves 6-8. Good over rice or broad noodles.

(Just in case the budget needs even more watching that week, use 1 cup evaporated milk plus 1 tablespoon of vinegar in place of the sour cream.)

One of the nicest things about the end of a meal is dessert — at least the menfolk think so. Your specialty can be homemade cheese pie, which is a luxury dessert (if you've ever priced the bakery's offerings); and it can cost you no more than an assortment of store-bought Danish pastry.

Strawberry Cheese Pie

1 unbaked graham cracker crust
12 ounces cream cheese (4 small packages or 1½ large)
2 eggs
½ cup sugar
1 teaspoon vanilla
½ cup sour cream

Preheat oven to 350°. In electric mixer, beat cheese, eggs, sugar and vanilla at medium speed until well-blended. Turn into pie shell. Bake for 35 minutes. Cool, then spread top of pie with sour cream. Add frozen or fresh strawberries; or blueberries; or pineapple chunks. May also be served plain. It's rich, so make those first slices small ones!

So there! You've got a gourmet flair for food preparation on a house staffer's budget. Your guests are guaranteed to depart sated and happy — and perhaps wondering how you manage so much on a resident's stipend.

when vomiting persists in the recovery room

When vomiting persists unabated in the recovery room, prompt institution of Tigan therapy will bring the emesis under control in a great majority of cases. Tigan is as effective an antiemetic as the most potent phenothiazines, without entailing any of their risks. Tigan may be administered with confidence since it does not cause tachycardia, potentiation of anesthesia, or significant hypotension.

Note: There are no known contraindications or special precautions to complicate Tigan therapy.

Tigan Injectable is supplied in 2-cc ampuls and 20-cc vials; Tigan is also available in 250-mg and 100-mg capsules and 200-mg suppositories.

Consult literature and dosage information, available on request, before prescribing.

TIGAN® Hydrochloride—4-(2-dimethylaminoethoxy)-N-(3,4,5-trimethoxybenzoyl) benzylamine hydrochloride

INJECTABLE

Tigan

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.

Tax Planning Makes Sens...a

Joseph Arkin, C.P.A.

It's done. Forget it until tax-time next year. Unfortunately, that was the reaction of many residents —and millions of other American taxpayers—as soon as their Federal tax forms were dropped in the mail.

Yet, tax attorneys and accountants, as well as agents of the Internal Revenue Service, are unanimous in their agreement on two important points:

- Last minute filing multiplies the possibility of costly errors.
- Planning ahead permits the taxpayer to take advantage of proper deductions available to him under the law.

In an effort to help you plan ahead, RESIDENT PHYSICIAN will publish tax information for house staffers in a new department, using a question and answer format. Your questions are welcome, and while personal letters are not possible in reply, your questions will be published whenever the answers would be helpful to other residents.

• *Address your questions to: Editor, Tax Clinic, Resident Physician, 1477 Northern Blvd., Manhasset, L. I. Personal replies cannot be made, but your question may be answered in future issues of RP.*

ns . . . *and dollars for you!*

Q and A

Q. I am employed as a resident and expend money for whites, gowns, gloves and incidentals of a like nature. I am not reimbursed for these expenses. Where do I deduct these costs on the tax return?

A. On your federal tax return, Form 1040, you deduct these on page two under the section "Miscellaneous."

The rule for deduction of uniforms, work clothes, etc., is that the costs, including purchase cost, cleaning, laundering, pressing, repairs, etc. are only deductible if they are:

(1) especially required by terms of your employment as being necessary for your employment; and

(2) they are not readily adaptable to general or continued wear to where they can be said to replace your street clothes or regular clothing.

It is established in practice through several cases that a surgeon or physician working in a hospital could deduct the costs incurred for his whites.

Q. Getting ready for next year, I want to keep tabs of my on-the-job expenses which are deductible. Could you provide a short check-list?

A. Malpractice insurance premiums, telephone, stationery, printing, postage, supplies, depreciation of own equip-

ment used on the job, subscriptions to professional magazines and trade journals, cost of whites, repair and laundering, books purchased having short useful life, depreciation of professional library, cost of fidelity bond if required by employer, cost of instruments having short, useful life, costs to attend conventions, educational costs, local unreimbursed carfares, travel expenses while away from home where required by terms of employment, dues paid to professional societies, and employment agency fees.

This list is not all-inclusive but just covers the usual expenses which most employed doctors incur.

(For a more complete discussion of convention expenses see RP, January 1961, and for educational costs see RP, October 1960.)

Q. Are there any tax cases that have been settled recently on the question of stipends received from hospitals and foundations by student-doctors in research or advanced studies?

A. Many. There is the case of Chander P. Bhalla (35 Tax Court No. 3) in which the National Science Foundation made a grant of $19,700 to the University of Tennessee to support pure research in the field of nuclear physics. The University, in connection with such grant, gave a graduate research assistantship to the taxpayer who was a candidate for a Ph.D. degree in physics at that University; and it allowed the taxpayer for his research work, a stipend of $175 a month for a period of nine months. Equivalent research was required by the University for all candidates for the particular degree for which Mr. Bhalla was a candidate. He would have been required to complete such a research assignment as a condition to receiving said degree, even if no stipend had been allowed to him. The University gave Mr. Bhalla credit toward such degree for the research and study that he performed under the above-mentioned graduate research assistantship. The primary purpose of his research and study was the furtherance of his training and education. The Tax Court held that under these circumstances the

will you help the mailman, your hospital and us?

Are you planning to move soon?

If so, will you please take a few seconds now* to fill out and mail the form below and help us in our efforts to have RESIDENT PHYSICIAN reach you promptly at your new hospital address?

* Please do it now — it will take us 30 days to process your change of address.

MAIL TO: RESIDENT PHYSICIAN, 1447 Northern Blvd., Manhasset, New York

Dr. ..... Specialty .....
Please print your name

Resident ☐ Intern ☐ Fellow ☐ ☐ Clinical ☐ Research ☐ Special
Please check one

New Hospital .....

New Hospital Street Address .....

City ..... Zone ..... State .....

My chief is Dr. (full name) .....

I expect to complete my training here: ..... month ..... year

Former Hospital Address:

Hospital Name ..... City ..... State .....

total amount of the stipend was excludible from his gross income under Section 117 of the 1954 Code.

Another case is that of Ethel M. Bonn (34 Tax Court No. 7). In this case Miss Bonn, a graduate physician, was accepted as a fellow in the school of psychiatry operated by the Menninger Foundation, and was appointed by the Veterans Administration to a residency in psychiatry at a VA hospital, where she performed valuable professional services. During 1954, and while a resident at the hospital, she received $2959.11 directly from the VA. The primary purpose of the hospital was the care and treatment of patients, and its standards for admission of patients were based on veteran status and need of treatment.

The Treasury Department tried to tax the stipend received and the case was decided by the Tax Court which held that the amount received constituted compensation for services rendered and was not excludible from income as a fellowship grant under Section 117, of the 1954 Revenue Code.

Q. I recently wrote an article which was published by a medical journal and for which I received an honorarium. Not being a professional writer, does this item constitute taxable income?

A. Yes it does. Any money received for personal services constitutes taxable income unless specifically exempted by law. The fact that this is an occasional income does not alter the situation.

Q. With reference to short-term profits made in the stock market, why is the profit taxed at 100%?

A. We haven't come to that—not yet, anyway! What is meant when the term 100% is used in connection with short-term stock market profits is that the total *profit* is taken into account. But this amount is then added to your other sources of income and taxed at the normal rate for your particular income bracket.

To illustrate. You buy 100 shares of ABC stock for $2000 and sell it two months later for $3000. Your profit

is $1000. It is short-term since it was realized within six months of your purchase.) This amount is added to your salary, dividends, interest and other items of taxable income and your tax computed in the normal manner.

Had you held the stock for *more than six months* you would have been required to pay tax on only 50% of the profit ($500)—with the further proviso that the actual tax on your profit can never exceed 25% of the total profit, or in our example, $250 ($1000 × 25%).

Q. I am presently employed as a resident, but I expect to enter practice soon and have already rented an office and have furnished it. Can I deduct my rental and other expenses?

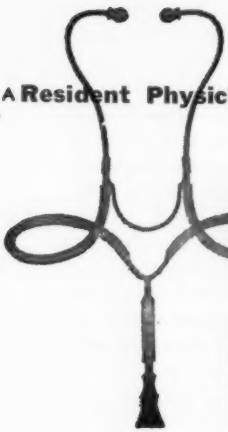
A. No. You are not entitled to deduct for business expenses during a period of time when you are not engaged in business. Also, should you actually engage in practice and then close your office to return to school for postgraduate studies, the expenses of maintaining your office during this interval will be non-deductible.

Q. I understand that my employment as a resident qualifies me under the Social Security Laws as a "currently insured worker." What benefits will my wife and child receive in the event of my death?

A. Here is a chart with the figures requested:

Average Monthly Pay	Widow	Widow plus one child	Widow plus two or more children
$ 50.00	$ 33.00	$ 49.50	$ 53.00
100.00	44.30	88.50	88.50
150.00	54.80	109.50	120.00
200.00	63.00	126.00	161.60
250.00	71.30	142.50	190.10
300.00	78.80	157.50	210.20
350.00	87.00	174.00	232.00
400.00	95.30	190.50	254.00

A **Resident Physician** MONTHLY FEATURE



Mediquiz

These questions were prepared especially for RESIDENT PHYSICIAN *by the Professional Examination Service, a division of the America Public Health Association. Answers will be found on page 169.*

1. A 43-year-old man ate a large meal at a wedding reception. Soon after, he vomited several cupfuls of partly digested food and experienced an intense, sharp epigastric pain. An injection of morphine, given by his physician, did not relieve the pain, which gradually became substernal and radiated around into the back between the scapulae. He was then brought to the hospital. When he was examined his temperature was 100° F., his respiration was 28 and labored, his pulse was 87 and regular, and his blood pressure was 95/50. He was cyanotic. There was subcutaneous emphysema about his thorax, his abdomen was rigid, and no masses were palpated. He had diffuse tenderness in both upper quadrants. Roentgen examination revealed no free air under the diaphragm.

The finding most compatible with this patient's condition is:

A) A transaminase of 400 units.

B) Q waves and elevated S-T reading in Lead I, aVL, V_5-V_6.

C) Direct communication with the peritoneal cavity as revealed by lipiodol swallow during roentgen examination.

D) A serum amylase of 2400 units.

E) Direct communication with the pleural cavity as revealed by lipiodol swallow during roentgen examination.

Continued on page 158

...does she know that only **you** can help?

Many patients are unaware that their physician is the best source of contraceptive advice. Your prescription for Ortho-Gynol or Ortho-Creme with a diaphragm assures her the best available contraceptive protection. Accurate tests* for spermicidal potency, as well as years of clinical use, demonstrate that ORTHO contraceptive products are instantaneously spermicidal. The choice between Ortho-Gynol and Ortho-Creme is one of individual esthetic preference.

Ortho-Gynol® vaginal jelly

Ortho-Creme® vaginal cream

*The spermicidal potency of all ORTHO products is controlled by the **Titration Test** and the **Sander-Cramer Test**, which more closely duplicate vaginal conditions during coitus than other tests.

WHENEVER A DIAPHRAGM IS INDICATED

Ortho

Mediquiz Booklets

• A third volume of 150 Mediquiz® questions, answers and references, compiled by the Professional Examination Service, Division of the American Public Health Association, is now available in booklet form for $1 per copy. The supply of booklets is limited. To be certain you get your copy, send your dollar now to:

Professional Examination Service
Department 66
American Public Health
Association
1790 Broadway
New York City 19, New York

• Please specify "Volume 3." Copies of Volumes 1 and 2 are available at $1 each for those who missed out on these valuable study aids.

• Other Mediquiz questions, never published in Resident Physician, but prepared especially for internists and general practitioners, are also available in reprint form. Write the address above, ask for "MT-Volume 1," and enclose $1 for each copy desired.

---

2. The main complaint in a subject with an aberrant subclavian artery is usually:

A) Angina pectoris.
B) Dysphagia.
C) Hoarseness.
D) Syncope.
E) Dizziness.

3. A finding that is specific to acute hemorrhagic pancreatitis is:

A) A high amylase content in the peritoneal fluid.
B) An elevated serum amylase value.
C) Abdominal calcifications seen on x-ray.
D) Elevated urinary amylase and lipase values.
E) Periumbilical petechiae.

4. Alimentary absorption of tetracyclines is markedly reduced in the presence of:

A) Aluminum salts.
B) Biliary obstruction.
C) Regional enteritis.
D) Mineral oil.
E) Sulfa drugs.

5. The short biological half-life of penicillin is due to its rapid:

A) Binding by serum proteins.
B) Hydrolysis by tissue penicillinases.
C) Oxidation.

D) Renal excretion.
E) Degradation in the liver.

6. Venous drainage from the upper lip is through the:
A) Maxillary vein.
B) Ophthalmic vein.
C) Labial vein.
D) Temporal vein.
E) Nasal vein.

7. The initial effect of salicylates on acid-base balance is to:
A) Increase the respiratory minute volume.
B) Affect the renal tubules.
C) Cause gastric irritation and chloride loss through vomiting.
D) Depress respiration.
E) Affect the adrenal cortex.

8. A spinal cord lesion destroying a lateral one-half of the cord gives rise to the:
A) Klippel-Feil deformity.
B) Brown-Séquard syndrome.
C) Guillain-Barré syndrome.
D) Osgood-Schlatter syndrome.
E) Arnold-Chiare syndrome.

9. The finding of carotenemia in a 12-year-old child might suggest the presence of:
A) Hypothyroidism.
B) Gilbert's disease.

Continued on page 160

C) A 'blind-loop' malabsorption syndrome.
D) Hemolytic jaundice.
E) Myotonia congenita.

10. A common occurrence in children with phenylpyruvic oligophrenia is:
A) Multiple polyposis coli.
B) Bladder diverticuli.
C) Eczema.
D) Meckel's diverticulum.
E) Appendicitis.

11. On the first day of life the urinary output averages:
A) 15 cc.
B) 50 cc.
C) 100 cc.
D) 150 cc.
E) 250 cc.

12. In Hirschsprung's disease an aganglionic internal rectal sphincter is:
A) Always incontinent.
B) Normal.
C) Intermittently incontinent.
D) Tighter than normal.
E) In tenesmus.

13. A syndrome characterized by red or cyanotic, painful, puffy extremities aggravated by warmth and relieved by cold, is known as:
A) Livido reticularis.
B) Pernio.
C) Raynaud's disease.
D) Acrocyanosis.
E) Erythromelalgia.

14. Subjects with a nephrotic syndrome due to lupus erythematosus disseminatus may excrete increased urine after the administration of:
A) Ethylenediamine tetra-acetate.
B) Nitrogen mustard.
C) Aminophylline.
D) Histamine.
E) Bethanechol chloride.

15. A frequent accompaniment of Paget's disease of the bone is:
A) Ischemic necrosis of affected bones.
B) Volkmann's contractures.

C) Peripheral vascular occlusion.

D) Increased vascularity of affected bones.

E) Joint mice.

16. The diagnosis of familial periodic paralysis may be established by a determination of:

A) Serum and urine magnesium levels.

B) Urinary 5-hydroxy-indoleacetic acid and EEG.

C) Serum and urine lead levels.

D) Serum potassium and urinary creatine.

E) Urinary 17 - ketosteroids and uric acid creatinine ratio.

17. The usual findings in senile osteoporosis are:

A) Decreased calcium and phosphorus, but normal serum phosphatase.

B) Increased urinary phosphorus, serum calcium, and phosphatase.

C) Elevated serum calcium and alkaline phosphatase.

D) Normal serum calcium, phosphorus, and alkaline phosphatase.

E) Increased urinary and fecal calcium, but normal serum calcium.

(Answers on page 169.)

What's the Doctor's Name?

He died on January 25, 1960, in his 80th year, having risen from poverty to a surgical, teaching, editing and writing career of prolific proportions and international recognition.

He was born in Hungary of a mother who was one of the first physicians graduated in obstetrics from the University of Budapest and a father who was a general practitioner. His maternal grandfather had practiced medicine in Boston. His son was to become a distinguished American surgeon, the two often joining their careers.

After his younger brother was killed in a pogrom in the spring of 1897, the family moved to Chicago to join a presumably wealthy relative. But the wealth was nonexistent. Supporting the family by giving violin lessons and playing in a gypsy orchestra, he earned his tuition at the University of Chicago by playing on the snare drums in the university band. He received his M.D. at Rush Medical College in 1904, the same year he became a U.S. citizen.

He founded the American Hospital in 1908, in Chicago, and was its chief surgeon for fifty years. Although reconstructive surgery and glandular transplantation were his chief interests, his diagnostic acumen and surgical technique attracted thousands of students and surgeons to Chicago to watch his work in every surgical field.

He founded the International College of Surgeons in Geneva in 1935 and became its permanent international secretary-general and editor-in-chief of its journal.

He belonged to the Mark Chicago Historical Society and served as president of the American Physicians' Art Association.

He was a founder of the Photographic Society of America and a fellow of the Royal Society of Arts and the Royal Photographic Society of Great Britain.

His autobiography, *A Surgeon's World,* was declared by Amy Loveman to be "an extremely readable book full of good anecdotes and crowded with interesting personalities."

Can you name this doctor?
Answer on page 171.